
# Commonwealth of Pennsylvania
# Department of Human Services
# Office of Mental Health and Substance Abuse Services

## 2022 External Quality Review Report
## Magellan Behavioral Health

April 2023

IPRO
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# Introduction

The final rule of the Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an external quality review organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs).[1] This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients.

The Commonwealth of Pennsylvania (PA) Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its EQRO to conduct the 2022 EQRs for HealthChoices (HC) behavioral health MCOs (BH-MCOs) and to prepare the annual technical reports. The subject of this report is one HC BH-MCO: Magellan Behavioral Health (MBH). Subsequent references to MCO in this report refer specifically to this HC BH-MCO.

## Overview

HC BH is the mandatory managed care program which provides Medical Assistance recipients with BH services in PA. The PA DHS OMHSAS determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with PA for the administration of the HC BH Program. In such cases, DHS holds the HC BH Program Standards and Requirements (PS&R) Agreement with the HC BH contractors, referred to in this report as "Primary Contractors." Primary Contractors, in turn, subcontract with a private-sector BH-MCO to manage the HC BH Program. Effective July 1, 2021, 66 of the 67 counties exercised their right of first opportunity to contract directly with a Primary Contractor. In 2021, DHS held one contract on behalf of an opt-out county, Greene.

In the interest of operational efficiency, numerous counties have come together to create HC oversight entities (HC-OEs) that coordinate the Primary Contractors while providing an oversight function of the BH-MCOs. In some cases, the HC-OE is the Primary Contractor and, in other cases, multiple Primary Contractors contract with an HC-OE to manage their HC BH Program. In the MBH managed care network, Bucks, Cambria, Delaware, Lehigh, Montgomery, and Northampton Counties hold contracts with MBH. All counties associated with MBH are individual Primary Contractors.

## Objectives

The EQR-related activities that must be included in the detailed technical reports are as follows:

- validation of performance improvement projects,
- validation of MCO performance measures,
- review to determine plan compliance with structure and operations standards established by the state (*Title 42 Code of Federal Regulations [CFR] Section [§] 438.358*), and
- validation of MCO network adequacy.

### Scope of EQR Activities

In accordance with the updates to the Centers for Medicare and Medicaid Services (CMS) EQRO Protocols released in late 2019,[2] this technical report includes eight core sections:

I. Validation of Performance Improvement Projects
II. Validation of Performance Measures
III. Review of Compliance with Medicaid Managed Care Regulations
IV. Validation of Network Adequacy
V. Quality Studies
VI. 2021 Opportunities for Improvement – MCO Response
VII. 2022 Strengths and Opportunities for Improvement
VIII. Summary of Activities

For the MCO, information for **Sections I** and **II** of this report is derived from IPRO's validation of the MCO's performance improvement projects (PIPs) and performance measure (PM) submissions. The PM validation, as conducted by IPRO, included a repeated measurement of three PMs: HEDIS Follow-Up After Hospitalization for Mental Illness, PA-specific Follow-Up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge. The information for compliance with Medicaid Managed Care Regulations in **Section III** of the report is derived from monitoring and reviews conducted by OMHSAS, as well as the oversight functions of the county or contracted entity, when applicable, against PA's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness

Assessment Instrument (RAI), as applicable. **Section IV** discusses the validation of MCO network adequacy in relation to existing federal and state standards that are covered in the Review of Compliance with Medicaid Managed Care Regulations, **Section III**. **Section V** discusses the Quality Study for the Certified Community Behavioral Health Clinic (CCBHC) federal demonstration and the Integrated Community Wellness Centers (ICWC) program. **Section VI**, 2021 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2021 (measurement year [MY] 2020) EQR annual technical report and presents the degree to which the MCO addressed each opportunity for improvement. **Section VII** includes a summary of the MCO's strengths and opportunities for improvement for this review period (MY 2021), as determined by IPRO, and a "report card" of the MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for HC BH quality performance of the MCO. Lastly, **Section VIII** provides a summary of EQR activities for the MCO for this review period. Also included are: **References** with a list of publications cited, as well as **Appendices** that include crosswalks of PEPS standards to pertinent BBA regulations and to OMHSAS-specific PEPS substandards, and results of the PEPS review for OMHSAS-specific standards.

# I: Validation of Performance Improvement Projects

## Objectives

*Title 42 CFR § 438.330(d)* establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

In accordance with current BBA regulations, IPRO validates at least one PIP for the MCO. The Primary Contractors and MCOs are required to implement improvement actions and to conduct follow-up, including, but not limited to, subsequent studies or remeasurement of previous studies in order to demonstrate improvement or the need for further action.

Calendar year (CY) 2021 saw the initial implementation stage of the new PIP project. During this stage, the PIP project was renamed "Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders" (SUD) in accordance with feedback received by the BH-MCOs and Primary Contractors during the first year of the PIP. The MCOs submitted their recalculated baselines which allowed for any recalibration of their measures and subsequent interventions as needed.

The Aim Statement for this PIP remained: "Significantly slow (and eventually stop) the growth of SUD prevalence among HC members while improving outcomes for those individuals with SUD, and also addressing racial and ethnic health disparities through a systematic and person-centered approach."

OMHSAS kept three common (for all MCOs) clinical objectives and one non-clinical population health objective:

1. Increase access to appropriate screening, referral, and treatment for members with an opioid use disorder (OUD) and/or other SUD;
2. Improve retention in treatment for members with an OUD and/or other SUD diagnosis;
3. Increase concurrent use of drug and alcohol counseling in conjunction with pharmacotherapy (medication-assisted treatment [MAT]); and
4. Develop a population-based prevention strategy with a minimum of at least two activities across the MCO/HC BH contracting networks. The two "activities" may fall under a single intervention or may compose two distinct interventions. Note that while the emphasis here is on population-based strategies, this non-clinical objective should be interpreted within the PIP lens to potentially include interventions that target or collaborate with providers and health care systems in support of a specific population (SUD) health objective.

Additionally, OMHSAS identified the following core performance indicators for the PEDTAR PIP:

1. **Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) –** This Healthcare Effectiveness Data and Information Set (HEDIS®) measure measures "the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder."[3] It contains two submeasures: continuity of care within 7 days, and continuity of care within 30 days of the index discharge or visit.
2. **Substance Use Disorder-Related Avoidable Readmissions (SAR) –** This is a PA-specific measure that measures avoidable readmissions for HC members 13 years of age and older discharged from detox, inpatient rehab, or residential services with an alcohol and other drug dependence (AOD) primary diagnosis. The measure requires 30 days of continuous enrollment (from the index discharge date) in the plan's HC program. The measure measures discharges, not individuals (starting from Day 1 of the MY, if multiple qualifying discharges within any 30-day period, only the earliest discharge is counted in the denominator). The SUD avoidable readmissions submeasure is intended here to complement FUI and recognizes that appropriate levels of care for individuals with SUD will depend on the particular circumstances and conditions of the individual. Therefore, for this submeasure, "avoidable readmission" will include detox episodes only.
3. **Mental Health-Related Avoidable Readmissions (MHR) –** This PA-specific measure will use the same denominator as SAR. The measure recognizes the high comorbidity rates of MH conditions among SUD members and is designed to assess screening, detection, early intervention, and treatment for MH conditions before they reach a critical

stage. For this measure, "readmission" will be defined as any acute inpatient admission with a primary MH diagnosis occurring within 30 days of a qualifying discharge from AOD detox, inpatient rehab, or residential services.

4. **Medication-Assisted Treatment for Opioid Use Disorder (MAT-OUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of opioid use disorder (OUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their OUD during the measurement period. This PA-specific measure is based on a CMS measure of "the percentage of Medicaid beneficiaries ages 18–64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year."[4] This measure will be adapted to include members age 16 years and older. BH counseling is not necessarily limited to addiction counseling.
5. **Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of moderate to severe alcohol use disorder (AUD) in the measurement period who received both BH counseling services and pharmacotherapy for their AUD during the measurement period. This PA-specific measure mirrors the logic of MAT-OUD, except for members age 16 years and older with severe or moderate AUD. BH counseling is not necessarily limited to addiction counseling.

MCOs are expected to submit results to IPRO on an annual basis. In addition to running as annual measures, quarterly rates will be used to enable measurement on a frequency that will support continuous monitoring and adjustment by the MCOs and their Primary Contractors.

This PIP project will extend from January 2021 through December 2023, with initial PIP proposals submitted in 2020 and a final report due in September 2024. The report marks the 19th EQR review to include validation of PIPs. With this PIP cycle, all MCOs/Primary Contractors share the same baseline period and timeline.

## Technical Methods of Data Collection and Analysis

The MCOs are required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with CMS protocols. These protocols follow a longitudinal format and capture information relating to:

- Project Topic
- Methodology
- Barrier Analysis, Interventions, and Monitoring
- Results
- Discussion

For the PEDTAR PIP, OMHSAS has designated the Primary Contractors to conduct quarterly PIP review calls with each MCO. The purpose of these calls will be to discuss ongoing monitoring of PIP activity, to discuss the status of implementing planned interventions, and to provide a forum for ongoing technical assistance, as necessary. Plans will be asked to provide up-to-date data on process measures and outcome measures prior to each meeting. Because of the level of detail provided during these meetings, rather than two semiannual submissions, MCOs will submit only one PIP interim report each September starting in 2021.

IPRO's validation of PIP activities is consistent with the protocol issued by CMS[5] and meets the requirements of the Final Rule on the EQR of Medicaid MCOs. IPRO's review evaluates each project for compliance with the 8 review elements listed below:

1. Topic Rationale
2. Aim
3. Methodology
4. Identified Study Population Barrier Analysis
5. Robust Interventions
6. Results
7. Discussion and Validity of Reported Improvement
8. Sustainability

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. Scoring for

each element is based on Met, Partially Met, and Not Met. Following the review of the listed elements, the review findings are considered to determine whether the PIP outcomes should be accepted as valid and reliable. The overall score expresses the level of compliance.

This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods. MY 2020 is the baseline year, and for MY 2021, elements were reviewed and scored using the Year 1 annual reports submitted in 2022. All MCOs received some level of guidance towards improving their submissions in these findings.

**Table 1.1** presents the terminologies used in the scoring process, their respective definitions, and their weight.

Table 1.1: Element Designation

| Element Designation | Definition | Designation Weight |
|---|---|---|
| Met | Met or exceeded the element requirements | 100% |
| Partially Met | Met essential requirements, but is deficient in some areas | 50% |
| Not Met | Has not met the essential requirements of the element | 0% |

When the PIPs are reviewed, all projects are evaluated on the same elements. The scoring matrix is completed for those review elements where activities have occurred during the review year. At the time of the review, a project can be reviewed for only a subset of elements. It will then be evaluated for other elements at a later date, according to the PIP submission schedule. Untimely reporting by the MCO, i.e., if not in accordance with the submission schedule, may be factored into the overall determination. At the time each element is reviewed, a finding is given of "Met," "Partially Met," or "Not Met". Elements receiving a "Met" will receive 100% of the points assigned to the element, "Partially Met" elements will receive 50% of the assigned points, and "Not Met" elements will receive 0%. Effective MY 2022, overall ratings below 85% (i.e., below "Met") will require action plans to remediate deficiencies in the PIP and/or its reporting.

The total points earned for each review element are weighted to determine the MCO's overall performance scores for a PIP. For the EQR PIPs, the highest achievable score for all demonstrable improvement elements—in this case, for MYs 2021 and 2022—is 80 points (80% x 100 points for full compliance; refer to **Table 1.2**).

Table 1.2: Review Element Scoring Weights (Scoring Matrix)

| Review Element | Standard | Scoring Weight |
|---|---|---|
| 1 | Topic/rationale | 5% |
| 2 | Aim | 5% |
| 3 | Methodology | 15% |
| 4 | Barrier analysis | 15% |
| 5 | Robust interventions | 15% |
| 6 | Results table | 5% |
| 7 | Discussion and validity of reported improvement | 20% |
| **Total demonstrable improvement score** | | **80%** |
| 8 | Sustainability[1] | 20% |
| **Total sustained improvement score** | | **20%** |
| **Overall project performance score** | | **100%** |

[1]At the time of this report, these standards were not yet applicable in the current phase of PIP implementation.

As also noted in **Table 1.2** (Scoring Matrix), PIPs are reviewed for the achievement of sustained improvement. Sustained improvement is assessed for the final year of a PIP, in this case, for MY 2023. The evaluation of the sustained improvement area has two review elements. These review elements have a total weight of 20%, for a possible maximum total of 20 points. To receive these points, the MCO must sustain improvement relative to baseline after achieving demonstrable improvement. The results for demonstrable and sustainable improvement will be reported by the MCO

and evaluated by the EQRO at the end of the current PIP cycle and reported in a subsequent EQR annual technical report.

## Findings

MBH successfully submitted a PEDTAR PIP proposal in the fall of 2020 based on an initial baseline period of July 1, 2019, through June 30, 2020. Implementation began in early 2021. The MCO subsequently resubmitted a revised proposal based on the full CY 2020 data with goals, objectives, and interventions recalibrated as needed. IPRO reviewed all baseline PIP submissions for adherence to PIP design principles and standards, including alignment with the statewide PIP aims and objectives as well as internal consistency and completeness. Clinical intervention highlights include comprehensive improvement to discharge planning addressing cultural factors, transportation barriers, and relapse prevention planning, incentivizing dually licensed outpatient providers, motivational interviewing training, and expanded knowledge, competency, and confidence among Certified Recovery Specialists and Certified Peer Specialists. For its population-based prevention strategy component, MBH is developing several educational information dissemination prevention activities to increase awareness around chronic pain, those prescribed opioid pain medication, and other SUD topics.

**Prevention, Early Detection, Treatment and Recovery (PEDTAR) for Substance Use Disorders**

For the Year 1 implementation review, the MCO scored 87.5% (70 points out of a maximum possible weighted score of 80 points; data not shown). MBH's PIP is characterized by robust interventions, monitoring and reporting. Opportunities for improvement were limited to discussion of preliminary findings.

Table 1.3: MBH PIP Compliance Assessments – Interim Year 1 Report

| Review Element | PEDTAR |
|---|---|
| Element 1. Project Topic/Rationale | Met |
| Element 2. Aim | Met |
| Element 3. Methodology | Met |
| Element 4. Barrier Analysis | Met |
| Element 5. Robust Interventions | Met |
| Element 6. Results Table | Met |
| Element 7. Discussion and Validity of Reported Improvement | Partially Met |

# II: Validation of Performance Measures

## Objectives

In MY 2021, OMHSAS's HC Quality Program required MCOs to run three PMs as part of their quality assessment and performance improvement (QAPI) program: the HEDIS Follow-Up After Hospitalization for Mental Illness (FUH), a PA-specific Follow-Up After Hospitalization for Mental Illness, and a PA-specific Readmission Within 30 Days of Inpatient Psychiatric Discharge studies were remeasured in 2021. IPRO validated all three PMs reported by each MCO for MY 2021 to ensure that the PMs were implemented to specifications and state reporting requirements (*Title 42 CFR § 438.330[b][2]*).

### Follow-Up After Hospitalization for Mental Illness

This PM assessed the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis, or who were in day/night treatment with a mental health provider on the date of discharge up to 7 and 30 days after hospital discharge. The measure continues to be of interest to OMHSAS for the purpose of comparing county, Primary Contractor, and BH-MCO rates to available national benchmarks and to prior years' rates.

MY 2002 was the first year that follow-up rates were reported. QI 1 and QI 2 utilize the HEDIS methodology for this measure. The PA-specific indicators were added to include services with high utilization in the HC BH Program that could not be mapped to any of the standard coding used in the HEDIS measure to identify follow-up office visits. Each year, the QI 1 and QI 2 specifications are aligned with the HEDIS Follow-Up After Mental Health Hospitalization measure. The PA-specific codes that are not included in the HEDIS measure are also reviewed for accuracy on an annual basis.

Typically, HEDIS FUH undergoes annual updates to its specifications. Among the updates in 2020 (MY 2019), the National Committee for Quality Assurance (NCQA) added the following reporting strata for FUH, ages: 6–17, 18–64, and 65 and over. These changes resulted in a change in the reporting of FUH results in this report, which are broken out by ages: 6–17, 18–64, and 6 and over (All Ages).

### Measure Selection and Description

In accordance with DHS guidelines, IPRO created the indicator specifications to resemble HEDIS specifications. For each indicator, the criteria specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications as needed. Indicator rates were calculated using only the BH-MCO's data systems to identify numerator positives (i.e., administratively).

This PM assessed the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis, or who were in day/night treatment with a mental health provider on the date of discharge up to 7 and 30 days after hospital discharge.

There were four separate measurements related to Follow-Up After Hospitalization. All utilized the same denominator but had different numerators.

### Eligible Population for HEDIS Follow-Up

The entire eligible population was used for all 24 Primary Contractors participating in the MY 2021 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:

- Members who had one (or more) hospital discharges from any acute care facility with a discharge date occurring between January 1 and December 1, 2021;
- A principal International Classification of Diseases, Ninth Revision (ICD-9) or International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code indicating one of the specified mental health disorders;
- Six (6) years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 1, 2021, greater than 30 days apart, with a principal diagnosis indicating one of the mental health disorders specified are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 1, 2021. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS MY 2021 methodology for the Follow-Up After Hospitalization for Mental Illness measure.

### HEDIS Follow-Up Indicators

**Quality Indicator 1 (QI 1): Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge (calculation based on industry standard codes used in HEDIS)**

Numerator: An ambulatory visit with a mental health practitioner up to 7 days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

**Quality Indicator 2 (QI 2): Follow-Up After Hospitalization for Mental Illness Within 30 Days After Discharge (calculation based on industry standard codes used in HEDIS)**

Numerator: An ambulatory visit with a mental health practitioner up to 30 days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

### Eligible Population for PA-Specific Follow-Up

The entire eligible population was used for all 24 Primary Contractors participating in the MY 2021 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:

- Members who had one (or more) hospital discharges from any acute care facility with a principal diagnosis of mental illness occurring between January 1 and December 2, 2021;
- Six (6) years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 2, 2021, greater than 30 days apart, with a principal diagnosis indicating one of the mental health disorders specified are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 2, 2021. The PA-specific measure has been adjusted to allow discharges up through December 2, 2021, which allows for the full 30-day follow-up period where same-day follow-up visits may be counted in the numerator.

### PA-Specific Follow-Up Indicators

**Quality Indicator A (QI A): Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge (calculation based on numerator 1 codes and additional PA-specific codes not used in HEDIS)**

Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to 7 days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

**Quality Indicator B (QI B): Follow-Up After Hospitalization for Mental Illness Within 30 Days after Discharge (calculation based on numerator 1 codes and additional PA-specific codes not used in HEDIS)**

Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to 30 days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

## Quality Indicator Significance

Mental health disorders contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. In 2019, an estimated 47.6 million adults aged 18 or older (19.1%) had any mental illness in the past year while an estimated 11.4 million adults in the nation had a serious persistent mental illness (SPMI) in the past year, which corresponds to 4.6% of all U.S. adults.[6] Additionally, individuals diagnosed with schizophrenia or bipolar disorder have elevated rates of preventable medical co-morbidities such as obesity, cardiovascular diseases, and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns, reduced use of preventive services, and substandard medical care that they receive.[7] Around one-third of adults with SPMI in any given year did not receive any mental health services.[8] Further research suggests that more than half of those with SPMI did not receive services because they could not afford the cost of care.[9] Cost of care broke down as follows: 60.8% of related expenses were attributed to loss of earnings, 31.5% were attributed to healthcare expenses, while 7.7% were attributed to payments for disability benefits.[10] For these reasons, timely and appropriate treatment for mental illnesses is essential.

It has long been recognized that continuity of care is critical to positive outcomes and to prevent long-term deterioration in people with SPMI.[11] As noted in *The State of Health Care Quality Report,*[12] appropriate treatment and follow-up care can reduce the duration of disability from mental illnesses and the likelihood of recurrence. An outpatient visit within at least 30 days (ideally, 7 days) of discharge ensures that the patient's transition to home and/or work is supported and that gains made during hospitalization are maintained. These types of contacts specifically allow physicians to ensure medication effectiveness and compliance and to identify complications early on in order to avoid more inappropriate and costly use of hospitals and emergency departments.[13] With the expansion of evidence-based practice in the recent decade, continuity has become a core principle in care delivery and in performance measurement for mental health services.[14] One way to improve continuity of care is to provide greater readiness of aftercare by shortening the time between discharge from the hospital and the first day of outpatient contact.[15]

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a long-standing concern of BH care systems, with some researchers having estimated that 40–60% of patients fail to connect with an outpatient clinician.[16] Over the course of a year, patients who have kept appointments have been shown to have a decreased chance of being re-hospitalized than those who do not follow up with outpatient care.[17]

There are various measures of treatment efficacy, such as service satisfaction, functional status, and health outcomes. Among them, rehospitalization rates continue to be used as a reliable indicator of the effectiveness of inpatient treatment.[18] Avoidable inpatient readmission is a step backward in treatment and a costly alternative to effective and efficient ambulatory care. Timely follow-up care, therefore, is an important component of comprehensive care and is an effective means to control the cost and maximize the quality of mental health services. Additionally, mental illness continues to impact the PA population, including those with substance abuse concerns or SUD.[19] Measuring appropriate care transitions for members with mental illness, therefore, carries wider implications for the OMHSAS quality area related to SUD prevalence and outcomes.

As noted, timely follow-up after hospitalization for mental illness has been and remains a focus for OMHSAS and results are reviewed for potential trends each year. MY 2021 results will be examined in the context of the COVID-19 pandemic, which has been implicated in rising prevalence of mental illness.[20] While factors such as those outlined in this section may persist and continue to impact follow-up rates, OMHSAS is exploring new and related areas of research as well as the factors that may impact optimal follow-up. OMHSAS will continue to discuss the development of new or enhanced initiatives with the goal of continual improvement of care.

## Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-Up After Hospitalization for Mental Illness, OMHSAS elected to retain and remeasure the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) indicator for this year's EQR. As directed by OMHSAS, IPRO developed the PM for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH-MCOs to perform another data collection and remeasurement of the PM for validation soon thereafter for MY 2007, and then for MY 2008. Remeasurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2021 study conducted in 2022 was the 15th remeasurement of this indicator. Four clarifications were made to the specifications for MY 2013. If

a member was known to have multiple member IDs in the MY, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish between a same-day readmission and a transfer to another acute facility. As with the Follow-Up After Hospitalization for Mental Illness measure, the rates provided are aggregated at the HC BH (statewide) level for MY 2021. This measure continued to be of interest to OMHSAS for the purposes of comparing Primary Contractor and BH-MCO rates to the OMHSAS performance goal and to prior rates.

This study examined BH services provided to members participating in the HC BH Program. For the indicator, the criteria specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. In order to identify the administrative numerator-positives, the date-of-service, and diagnosis/procedure code criteria were outlined, as were other specifications as needed. This measure's calculation was based on administrative data only.

This PM assessed the percentage of discharges for enrollees from inpatient acute psychiatric care that were followed by an inpatient acute psychiatric care readmission within 30 days of the previous discharge.

### Eligible Population

The entire eligible population was used for all 67 counties and 24 Primary Contractors participating in the MY 2021 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:

- Members with one or more hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 1, 2021;
- A principal ICD-9 or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event; and
- The claim was clearly identified as a discharge.

The numerator comprised members who were readmitted to inpatient acute psychiatric care within 30 days of the previous inpatient psychiatric discharge. One significant change to this specification is the extension of the end date for discharges from December 1$^{st}$ to December 2$^{nd}$ to accommodate the full 30 days before the end of the MY.

## Technical Methods of Data Collection and Analysis

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH-MCOs for each Primary Contractor participating in the current study. The source for all administrative data was the BH-MCOs' transactional claims systems. Each BH-MCO was also required to submit the follow-up rates calculated for the four indicators, along with their data files for validation purposes. The BH-MCOs were given the opportunity for resubmission, as necessary.

### Performance Goals

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure, as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. In 2018 (MY 2017), in part to better account for the growing population of members 65 years old and older, OMHSAS changed its benchmarking to the FUH All Ages (6+ years old) measure. OMHSAS established a 3-year goal for the state to meet or exceed the 75th percentile for the All Ages measure, based on the annual HEDIS Quality Compass® published percentiles for 7-day and 30-day FUH. This change in 2018 also coincided with a more prospective and proactive approach to goal-setting. BH-MCOs were given interim goals for MY 2019 for both the 7-day and 30-day FUH All Ages rates based on their MY 2017 results. These MY 2017 results were reported in the 2018 annual technical report.

HEDIS percentiles for the 7-day and 30-day FUH All-Ages indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis (RCA) and corresponding quality improvement plan (QIP) for each underperforming indicator. Rates for the HEDIS FUH 7-day and 30-day indicators that fall below the 75th percentile for each of these respective indicators will result in a request to the BH-MCO for an RCA and QIP. This process is further discussed in **Section VI**.

For REA, OMHSAS designated the PM goal as better than (i.e., less than) or equal to 11.75% for the participating BH-MCOs and counties. For this measure, lower rates indicate better performance.

Although not part of this report, OMHSAS sponsored in 2019 the rollout of an IPRO-hosted Tableau® server reporting platform, which allows users, including BH-MCOs and Primary Contractors, to interactively query data and produce reports on PMs. These reports include statistical and non-statistical summaries and comparisons of rates by various stratifications, including by demographics, such as race and ethnicity, as well as by participation status in the Medicaid Expansion program (PA continued its Medicaid Expansion under the Affordable Care Act in 2021). This interactive reporting provides an important tool for BH-MCOs and their Primary Contractors to set performance goals as well as monitor progress toward those goals.

## Data Analysis

The quality indicators were defined as rates, based on a numerator of qualifying events or members and a denominator of qualifying events or members, defined according to the specifications of the measure. The HC aggregate (statewide) for each indicator was the total numerator divided by the total denominator, which represented the rate derived for the statewide population of denominator-qualifying events or members. Year-to-year comparisons to MY 2020 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a *Z*-test statistic for comparing proportions for two independent samples was used. To calculate the test statistic, the two proportions were averaged ("pooled") through the following formula:

$$\hat{p} = \frac{\mathrm{N1} + \mathrm{N2}}{\mathrm{D1} + \mathrm{D2}}$$

Where:

*N*1 = Current year (MY 2021) numerator,
*N*2 = Prior year (MY 2020) numerator,
*D*1 = Current year (MY 2021) denominator, and
*D*2 = Prior year (MY 2020) denominator.

The single proportion estimate was then used for estimating the standard error (SE). *Z*-test statistic was obtained by dividing the difference between the proportions by the standard error of the difference. Analysis that uses the *Z*-test assumes that the data and their test statistics approximate a normal distribution. To correct for approximation error, the Yates correction for continuity was applied:

$$z - statistic = \frac{ABS(p1 - p2) - 0.5(\frac{1}{D1} + \frac{1}{D2})}{\sqrt{\hat{p}(1-\hat{p})[\frac{1}{D1} + \frac{1}{D2}]}}$$

Where:

*p*1 = Current year (MY 2021) quality indicator rate, and
*p*2 = Prior year (MY 2020) quality indicator rate.

Two-tailed statistical significance tests were conducted at $p = 0.05$ to test the null hypothesis of:

$$H_0: p1 = p2$$

Percentage point difference (PPD) as well as 95% confidence intervals for difference between the two proportions were also calculated. Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

### Limitations

The tables and figures in this section present rates, confidence intervals, and tests of statistical significance for Primary Contractors. Caution should be exercised when interpreting results for small denominators. A denominator of 100 or greater is preferred for drawing conclusions from *Z*-tests of the PM results. In addition, the above analysis assumes that the proportions being compared come from independent samples. To the extent that this is not the case, the findings should be interpreted with caution.

## Conclusions and Comparative Findings

The HEDIS follow-up indicators are presented for three age groups: ages 18–64 years, ages 6 years and older, and ages 6–17 years. The 6+ years old ("All Ages") results are presented to show the follow-up rates for the overall HEDIS population, and the 6–17 years old age group results are presented to support the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements. The results for the PA-specific follow-up indicators are presented for ages 6+ years old only.

The results are presented at the BH-MCO and Primary Contractor level. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (and Primary Contractor with the same contracted BH-MCO). The Primary Contractor-specific rates were calculated using the numerators and denominators for that particular Primary Contractor. For each of these rates, the 95% confidence interval (CI) is reported. The HC BH aggregate (statewide) rates were also calculated for the indicators.

BH-MCO-specific rates were compared to the HC BH statewide rates to determine if they were statistically significantly above or below that value. Statistically significant BH-MCO differences are noted. Primary Contractor-specific rates were also compared to the HC BH statewide rates to determine if they were statistically significantly above or below that value. Statistically significant Primary Contractor-specific differences are noted.

The HEDIS follow-up results for the All-Ages and 18–64 years old age groups are compared to the HEDIS 2021 national percentiles to show BH-MCO and Primary Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile. The HEDIS follow-up results for the 6–17 years old age group are not compared to HEDIS benchmarks.

### I: HEDIS Follow-Up Indicators

**(a) Age Group: 18–64 Years Old**

**Table 2.1** shows the MY 2021 results for both the HEDIS 7-day and 30-day follow-up measures for members 18–64 years old compared to MY 2020.

Table 2.1: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Indicators (18–64 Years)

| | MY 2021 | | | | | | MY 2021 Rate Comparison to: | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 95% CI | | | MY 2020 | | |
| Measure[1] | (N) | (D) | % | Lower | Upper | MY 2020 % | PPD | SSD | MY 2021 HEDIS Medicaid Percentiles |
| **QI1 - HEDIS 7-Day Follow-Up (18–64 Years)** | | | | | | | | | |
| Statewide | 9984 | 29137 | **34.3%** | 33.7% | 34.8% | 36.4% | -2.2 | YES | Below 75th Percentile, Above 50th Percentile |
| Magellan | 1712 | 5017 | **34.1%** | 32.8% | 35.4% | 35.1% | -0.9 | NO | Below 75th Percentile, Above 50th Percentile |
| Bucks | 296 | 832 | **35.6%** | 32.3% | 38.9% | 38.0% | -2.5 | NO | Below 75th Percentile, Above 50th Percentile |
| Cambria | 151 | 415 | **36.4%** | 31.6% | 41.1% | 33.0% | 3.4 | NO | Below 75th Percentile, Above 50th Percentile |
| Delaware | 304 | 950 | **32.0%** | 29.0% | 35.0% | 31.9% | 0.1 | NO | Below 50th Percentile, Above 25th Percentile |
| Lehigh | 349 | 1049 | **33.3%** | 30.4% | 36.2% | 35.9% | -2.6 | NO | Below 75th Percentile, Above 50th Percentile |

| Measure[1] | MY 2021 (N) | MY 2021 (D) | MY 2021 % | 95% CI Lower | 95% CI Upper | MY 2020 % | MY 2021 Rate Comparison to: MY 2020 PPD | MY 2020 SSD | MY 2021 HEDIS Medicaid Percentiles |
|---|---|---|---|---|---|---|---|---|---|
| Montgomery | 438 | 1182 | **37.1%** | 34.3% | 39.9% | 36.6% | 0.4 | NO | Below 75th Percentile, Above 50th Percentile |
| Northampton | 174 | 589 | **29.5%** | 25.8% | 33.3% | 33.4% | -3.9 | NO | Below 50th Percentile, Above 25th Percentile |
| **QI2 - HEDIS 30-Day Follow-Up (18–64 Years)** | | | | | | | | | |
| Statewide | 15653 | 29137 | **53.7%** | 53.1% | 54.3% | 55.7% | -2.0 | YES | Below 75th Percentile, Above 50th Percentile |
| Magellan | 2717 | 5017 | **54.2%** | 52.8% | 55.5% | 55.9% | -1.7 | NO | Below 75th Percentile, Above 50th Percentile |
| Bucks | 468 | 832 | **56.3%** | 52.8% | 59.7% | 60.1% | -3.9 | NO | Below 75th Percentile, Above 50th Percentile |
| Cambria | 245 | 415 | **59.0%** | 54.2% | 63.9% | 63.9% | -4.8 | NO | Below 75th Percentile, Above 50th Percentile |
| Delaware | 447 | 950 | **47.1%** | 43.8% | 50.3% | 48.4% | -1.4 | NO | Below 50th Percentile, Above 25th Percentile |
| Lehigh | 562 | 1049 | **53.6%** | 50.5% | 56.6% | 55.5% | -2.0 | NO | Below 75th Percentile, Above 50th Percentile |
| Montgomery | 684 | 1182 | **57.9%** | 55.0% | 60.7% | 57.5% | 0.4 | NO | Below 75th Percentile, Above 50th Percentile |
| Northampton | 311 | 589 | **52.8%** | 48.7% | 56.9% | 54.8% | -2.0 | NO | Below 50th Percentile, Above 25th Percentile |

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 rates.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

**Figure 2.1** is a graphical representation of MY 2021 HEDIS FUH 7- and 30-day follow-up rates in the 18–64 years old population for MBH and its associated Primary Contractors. The orange line represents the MCO average.

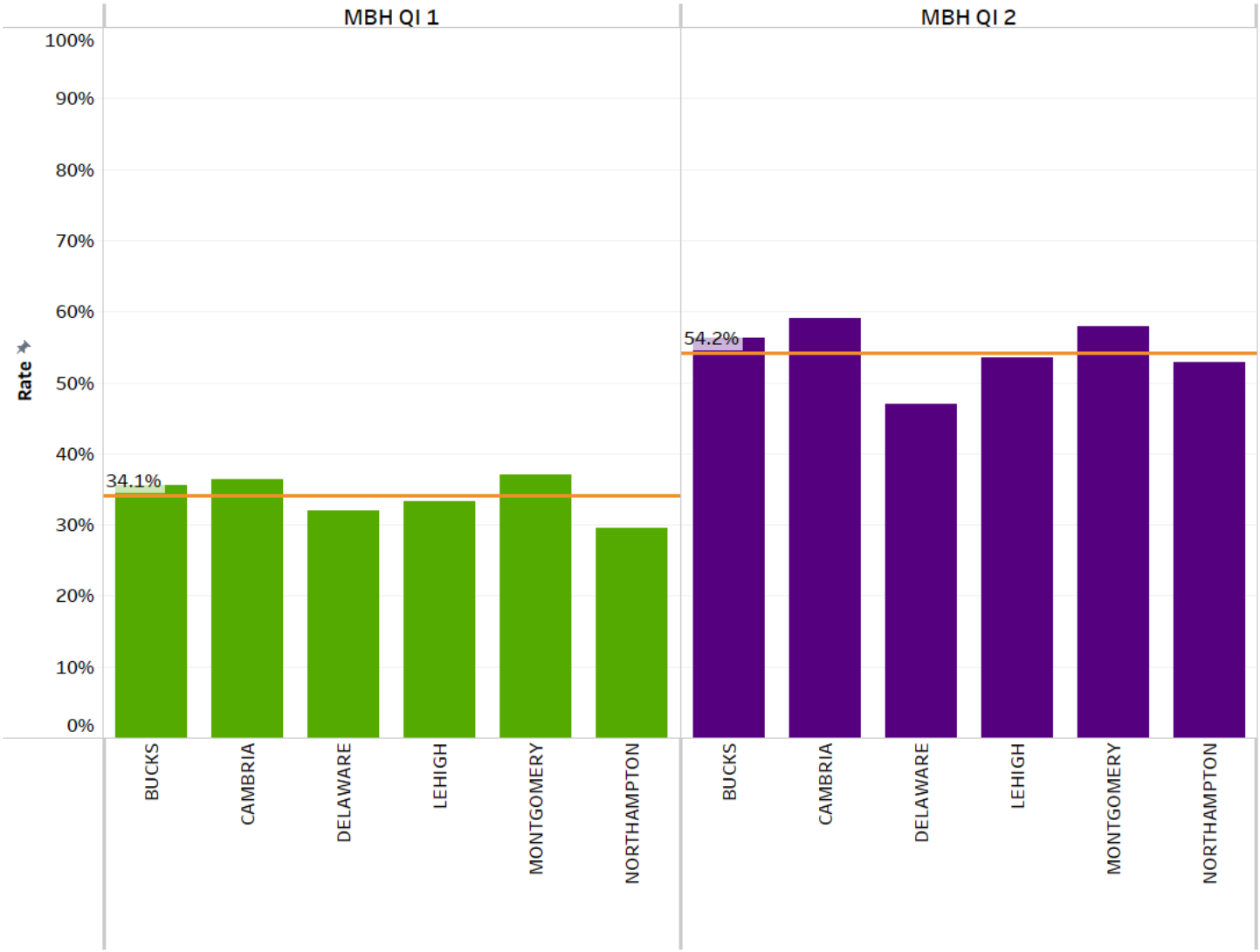


Figure 2.1: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years).

**Figure 2.2** shows the HC BH (statewide) rates for this age cohort and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the HC BH (statewide) rate.

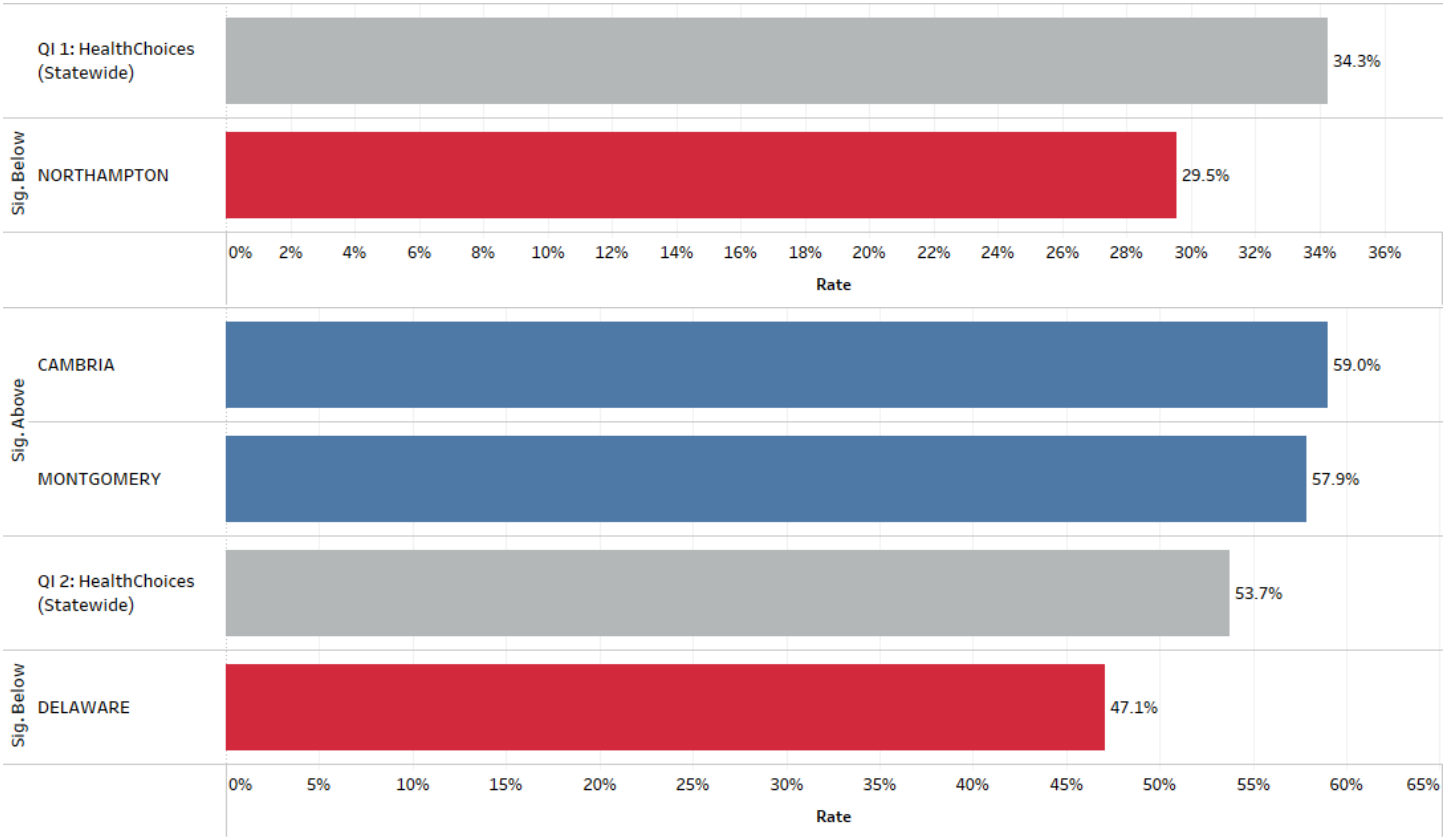


Figure 2.2: Statistically Significant Differences in MBH Contractor MY 2021 HEDIS FUH Rates (18–64 Years). MBH Primary Contractor MY 2021 HEDIS FUH rates for 18–64 years of age that are significantly different than HC BH (statewide) MY 2021 HEDIS FUH rates (18–64 years).

**(b) Overall Population: 6+ Years Old**

The MY 2021 HC aggregate HEDIS and MBH are shown in **Table 2.2**.

Table 2.2: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Indicators (All Ages)

| | MY 2021 | | | | | MY 2020 | MY 2021 Rate Comparison to: | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 95% CI | | | MY 2020 | | |
| Measure[1] | (N) | (D) | % | Lower | Upper | MY 2020 % | PPD | SSD | MY 2021 HEDIS Medicaid Percentiles |
| **QI1 - HEDIS 7-Day Follow-Up (Overall)** | | | | | | | | | |
| Statewide | 14140 | 37506 | **37.7%** | 37.2% | 38.2% | 39.8% | -2.1 | YES | Below 50th Percentile, Above 25th Percentile |
| Magellan | 2284 | 6414 | **35.6%** | 34.4% | 36.8% | 36.6% | -1.0 | NO | Below 50th Percentile, Above 25th Percentile |
| Bucks | 418 | 1081 | **38.7%** | 35.7% | 41.6% | 39.7% | -1.0 | NO | Below 75th Percentile, Above 50th Percentile |
| Cambria | 182 | 532 | **34.2%** | 30.1% | 38.3% | 32.8% | 1.4 | NO | Below 50th Percentile, Above 25th Percentile |
| Delaware | 386 | 1158 | **33.3%** | 30.6% | 36.1% | 33.3% | 0.0 | NO | Below 50th Percentile, Above 25th Percentile |
| Lehigh | 460 | 1324 | **34.7%** | 32.1% | 37.3% | 37.3% | -2.5 | NO | Below 50th Percentile, Above 25th Percentile |
| Montgomery | 580 | 1509 | **38.4%** | 35.9% | 40.9% | 38.7% | -0.2 | NO | Below 75th Percentile, Above 50th Percentile |
| Northampton | 258 | 810 | **31.9%** | 28.6% | 35.1% | 35.1% | -3.2 | NO | Below 50th Percentile, Above 25th Percentile |
| **QI2 - HEDIS 30-Day Follow-Up (Overall)** | | | | | | | | | |
| Statewide | 21707 | 37506 | **57.9%** | 57.4% | 58.4% | 59.4% | -1.6 | YES | Below 50th Percentile, Above 25th Percentile |
| Magellan | 3663 | 6414 | **57.1%** | 55.9% | 58.3% | 58.3% | -1.2 | NO | Below 50th Percentile, Above 25th Percentile |
| Bucks | 651 | 1081 | **60.2%** | 57.3% | 63.2% | 62.3% | -2.0 | NO | Below 75th Percentile, Above 50th Percentile |
| Cambria | 318 | 532 | **59.8%** | 55.5% | 64.0% | 66.2% | -6.4 | YES | Below 75th Percentile, Above 50th Percentile |
| Delaware | 584 | 1158 | **50.4%** | 47.5% | 53.4% | 51.1% | -0.7 | NO | Below 25th Percentile |
| Lehigh | 741 | 1324 | **56.0%** | 53.3% | 58.7% | 58.1% | -2.1 | NO | Below 50th Percentile, Above 25th Percentile |
| Montgomery | 909 | 1509 | **60.2%** | 57.7% | 62.7% | 60.0% | 0.2 | NO | Below 75th Percentile, Above 50th Percentile |
| Northampton | 460 | 810 | **56.8%** | 53.3% | 60.3% | 56.8% | -0.1 | NO | Below 50th Percentile, Above 25th Percentile |

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 rates.

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

**Figure 2.3** is a graphical representation of the MY 2021 HEDIS FUH follow-up rates for MBH and its associated Primary Contractors. The orange line represents the MCO average.

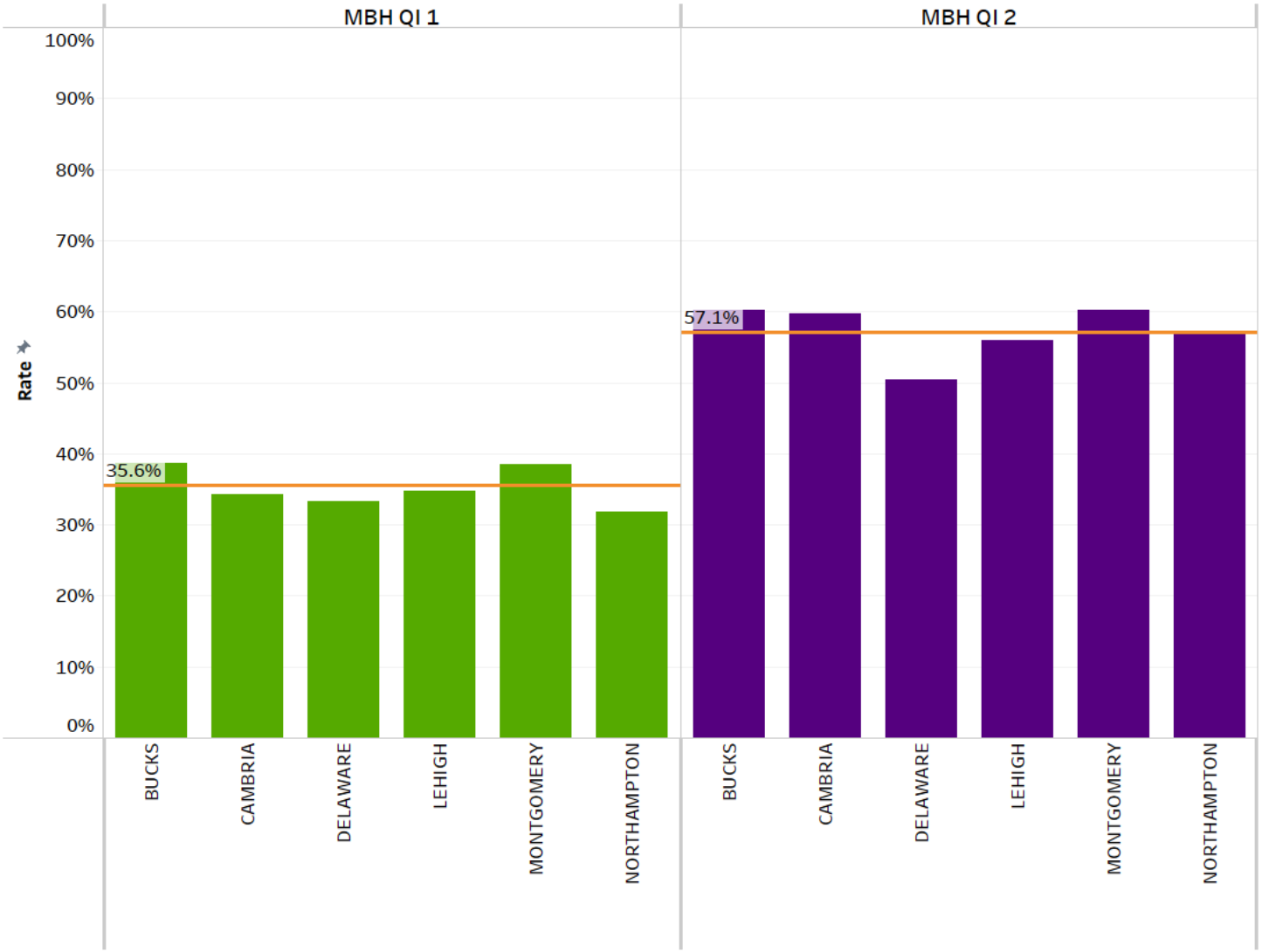


Figure 2.3: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages).

**Figure 2.4** shows the HC BH (statewide) rates and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than its statewide benchmark.

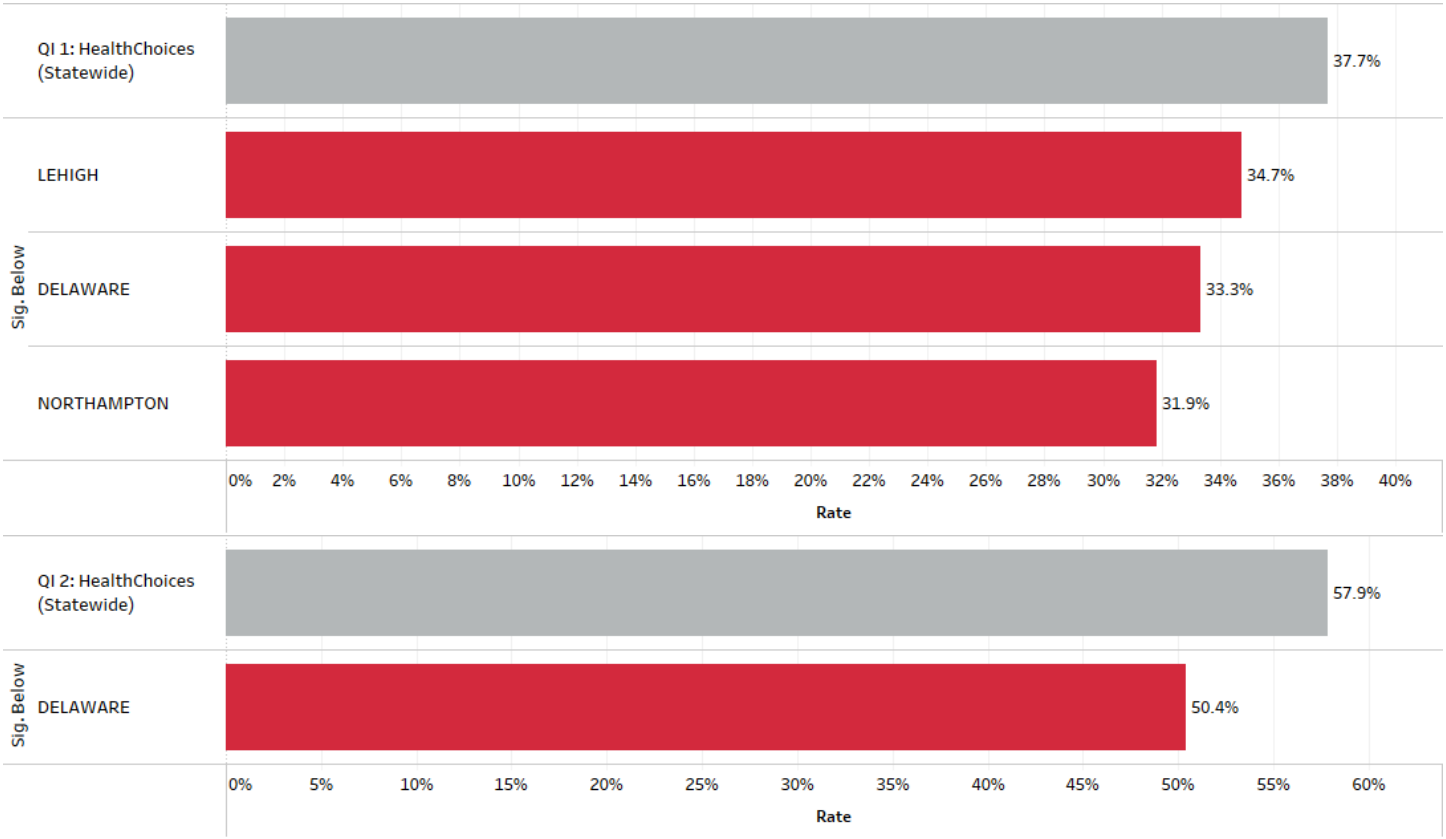


Figure 2.4: Statistically Significant Differences in MBH Contractor MY 2021 HEDIS FUH Rates (All Ages). MBH Primary Contractor MY 2021 HEDIS FUH rates for all ages that are significantly different than HC BH (statewide) MY 2021 HEDIS FUH rates (all ages).

**(c) Age Group: 6–17 Years Old**

**Table 2.3** shows the MY 2021 results for both the HEDIS FUH 7-day and 30-day follow-up measures for members 6–17 years old compared to MY 2020.

Table 2.3: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Indicators (6–17 Years)

| Measure[1] | MY 2021 (N) | MY 2021 (D) | MY 2021 % | 95% CI Lower | 95% CI Upper | MY 2020 % | MY 2021 Rate Comparison to MY 2020 PPD | MY 2021 Rate Comparison to MY 2020 SSD |
|---|---|---|---|---|---|---|---|---|
| **QI1 - HEDIS 7-Day Follow-Up (6–17 Years)** | | | | | | | | |
| Statewide | 3988 | 7625 | **52.3%** | 51.2% | 53.4% | 55.2% | -2.9 | YES |
| Magellan | 545 | 1298 | **42.0%** | 39.3% | 44.7% | 43.5% | -1.5 | NO |
| Bucks | 117 | 234 | **50.0%** | 43.4% | 56.6% | 46.7% | 3.3 | NO |
| Cambria | 30 | 112 | **26.8%** | 18.1% | 35.4% | 33.0% | -6.2 | NO |
| Delaware | 79 | 195 | **40.5%** | 33.4% | 47.7% | 41.2% | -0.7 | NO |
| Lehigh | 98 | 244 | **40.2%** | 33.8% | 46.5% | 43.7% | -3.6 | NO |
| Montgomery | 138 | 303 | **45.5%** | 39.8% | 51.3% | 47.0% | -1.5 | NO |
| Northampton | 83 | 210 | **39.5%** | 32.7% | 46.4% | 42.8% | -3.2 | NO |

| Measure[1] | MY 2021 (N) | MY 2021 (D) | MY 2021 % | 95% CI Lower | 95% CI Upper | MY 2020 % | MY 2021 Rate Comparison to MY 2020 PPD | MY 2021 Rate Comparison to MY 2020 SSD |
|---|---|---|---|---|---|---|---|---|
| **QI2 - HEDIS 30-Day Follow-Up (6–17 Years)** | | | | | | | | |
| Statewide | 5787 | 7625 | **75.9%** | 74.9% | 76.9% | 77.1% | -1.2 | NO |
| Magellan | 907 | 1298 | **69.9%** | 67.3% | 72.4% | 70.1% | -0.2 | NO |
| Bucks | 177 | 234 | **75.6%** | 69.9% | 81.4% | 72.4% | 3.3 | NO |
| Cambria | 71 | 112 | **63.4%** | 54.0% | 72.8% | 76.7% | -13.3 | YES |
| Delaware | 134 | 195 | **68.7%** | 62.0% | 75.5% | 66.4% | 2.4 | NO |
| Lehigh | 160 | 244 | **65.6%** | 59.4% | 71.7% | 70.2% | -4.7 | NO |
| Montgomery | 217 | 303 | **71.6%** | 66.4% | 76.9% | 70.7% | 0.9 | NO |
| Northampton | 148 | 210 | **70.5%** | 64.1% | 76.9% | 66.7% | 3.8 | NO |

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

**Figure 2.5** is a graphical representation of the MY 2021 HEDIS FUH 7- and 30-Day follow-up rates in the 6–17 years old population for MBH and its associated Primary Contractors. The orange line represents the MCO average.

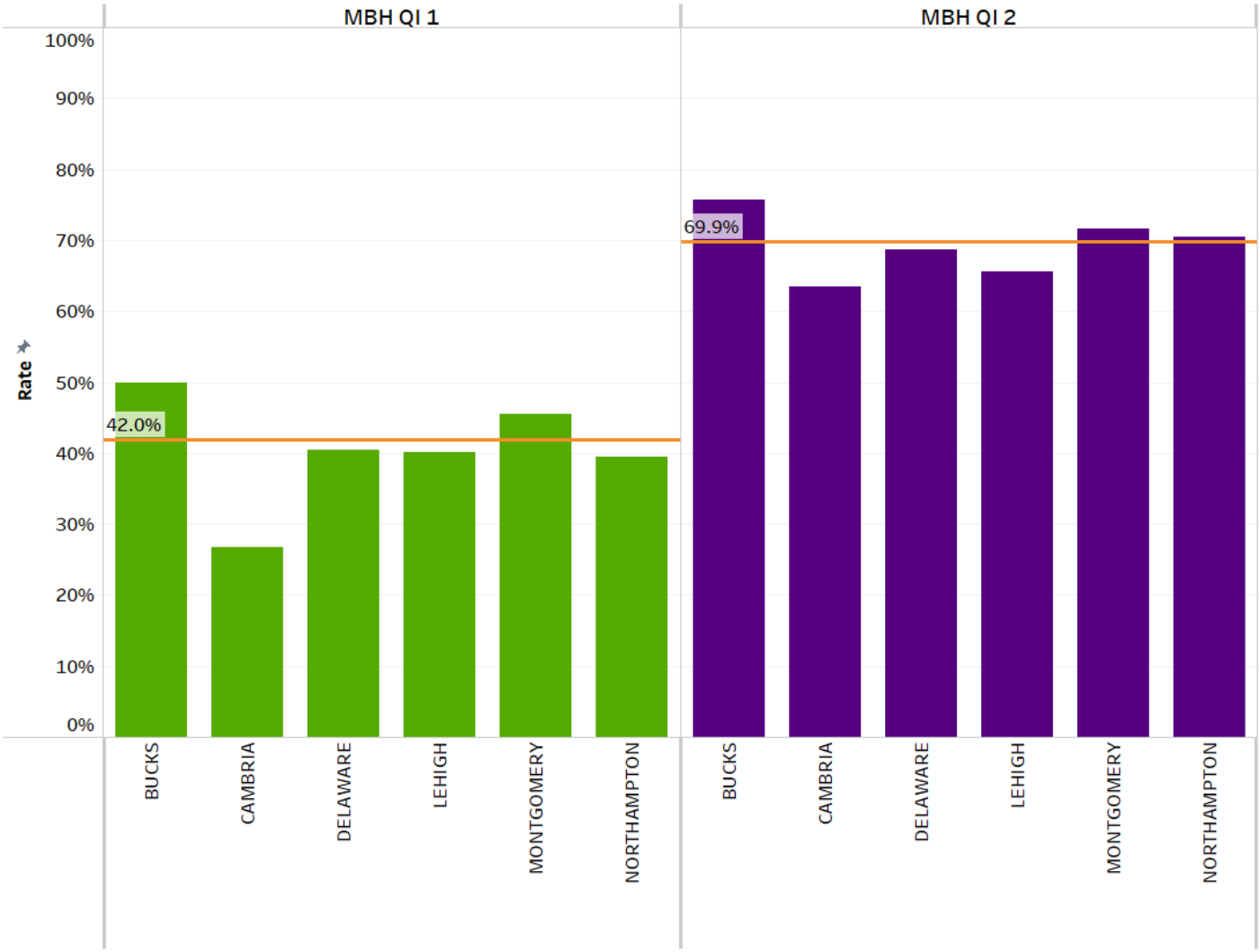


Figure 2.5: MY 2021 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years).

**Figure 2.6** shows the HC BH (statewide) rates for this age cohort and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the statewide rates.

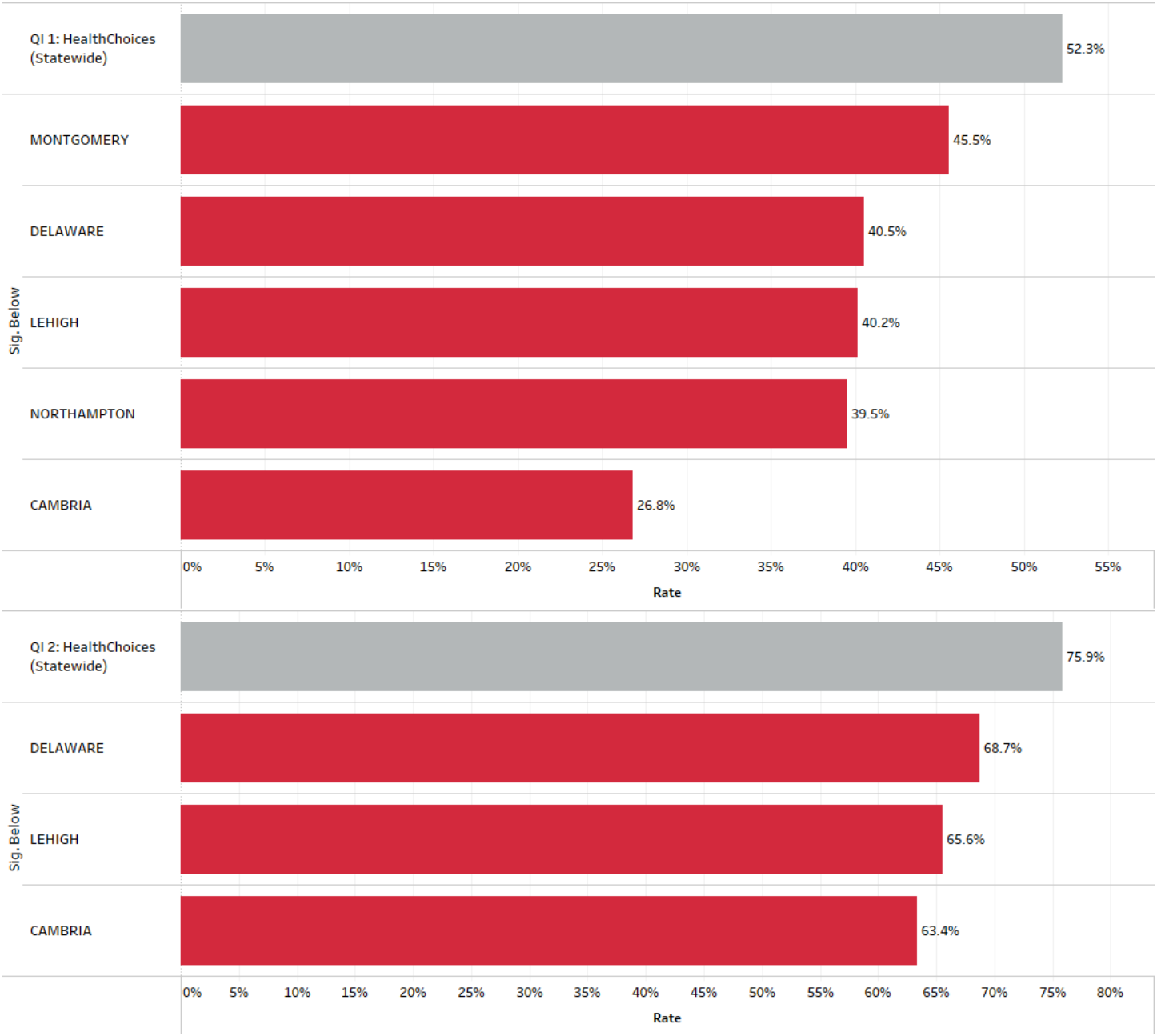


Figure 2.6: Statistically Significant Differences in MBH Contractor MY 2021 HEDIS FUH Rates (6–17 Years). MBH Primary Contractor MY 2021 HEDIS FUH rates for 6–17 years of age that are significantly different than HC BH (statewide) MY 2021 HEDIS FUH rates (6–17 years).

## II: PA-Specific Follow-Up Indicators

**(a) Overall Population: 6+ Years Old**

**Table 2.4** shows the MY 2021 PA-specific FUH 7- and 30-day follow-up indicators for all ages compared to MY 2020.

Table 2.4: MY 2021 PA-Specific FUH 7- and 30-Day Follow-Up Indicators (All Ages)

| Measure[1] | MY 2021 (N) | MY 2021 (D) | MY 2021 % | 95% CI Lower | 95% CI Upper | MY 2020 % | MY 2021 Rate Comparison to MY 2020 PPD | MY 2021 Rate Comparison to MY 2020 SSD |
|---|---|---|---|---|---|---|---|---|
| **QI A - PA-Specific 7-Day Follow-Up (Overall)** | | | | | | | | |
| Statewide | 18376 | 37634 | **48.8%** | 48.3% | 49.3% | 52.3% | -3.5 | YES |
| Magellan | 2963 | 6414 | **46.2%** | 45.0% | 47.4% | 49.0% | -2.8 | YES |
| Bucks | 531 | 1081 | **49.1%** | 46.1% | 52.1% | 51.6% | -2.5 | NO |
| Cambria | 262 | 532 | **49.2%** | 44.9% | 53.6% | 51.7% | -2.5 | NO |
| Delaware | 475 | 1158 | **41.0%** | 38.1% | 43.9% | 43.6% | -2.6 | NO |
| Lehigh | 593 | 1324 | **44.8%** | 42.1% | 47.5% | 47.3% | -2.5 | NO |
| Montgomery | 770 | 1509 | **51.0%** | 48.5% | 53.6% | 53.3% | -2.3 | NO |
| Northampton | 332 | 810 | **41.0%** | 37.5% | 44.4% | 47.5% | -6.5 | YES |
| **QI B - PA-Specific 30-Day Follow-Up (Overall)** | | | | | | | | |
| Statewide | 24798 | 37634 | **65.9%** | 65.4% | 66.4% | 68.3% | -2.4 | YES |
| Magellan | 3978 | 6414 | **62.0%** | 60.8% | 63.2% | 64.2% | -2.2 | YES |
| Bucks | 691 | 1081 | **63.9%** | 61.0% | 66.8% | 66.7% | -2.8 | NO |
| Cambria | 356 | 532 | **66.9%** | 62.8% | 71.0% | 72.3% | -5.4 | NO |
| Delaware | 633 | 1158 | **54.7%** | 51.8% | 57.6% | 55.8% | -1.2 | NO |
| Lehigh | 816 | 1324 | **61.6%** | 59.0% | 64.3% | 64.4% | -2.7 | NO |
| Montgomery | 979 | 1509 | **64.9%** | 62.4% | 67.3% | 67.4% | -2.5 | NO |
| Northampton | 503 | 810 | **62.1%** | 58.7% | 65.5% | 63.1% | -1.0 | NO |

[1] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 rates.

MY: measurement year; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

**Figure 2.7** is a graphical representation of the MY 2021 PA-specific follow-up rates for MBH and its associated Primary Contractors. The orange line represents the MCO average.

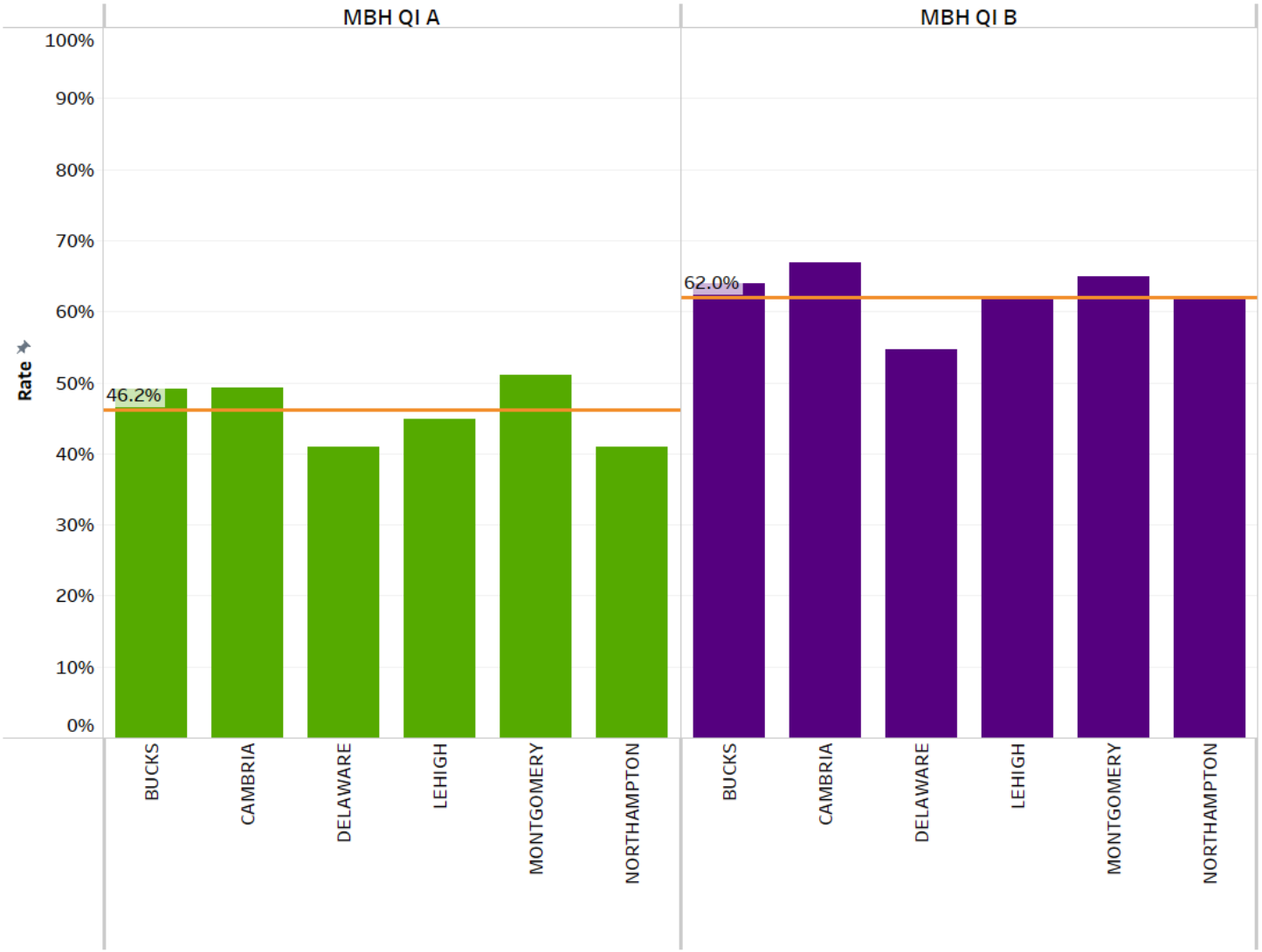


Figure 2.7: MY 2021 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages).

**Figure 2.8** shows the HC BH (statewide) rates and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the statewide benchmark.

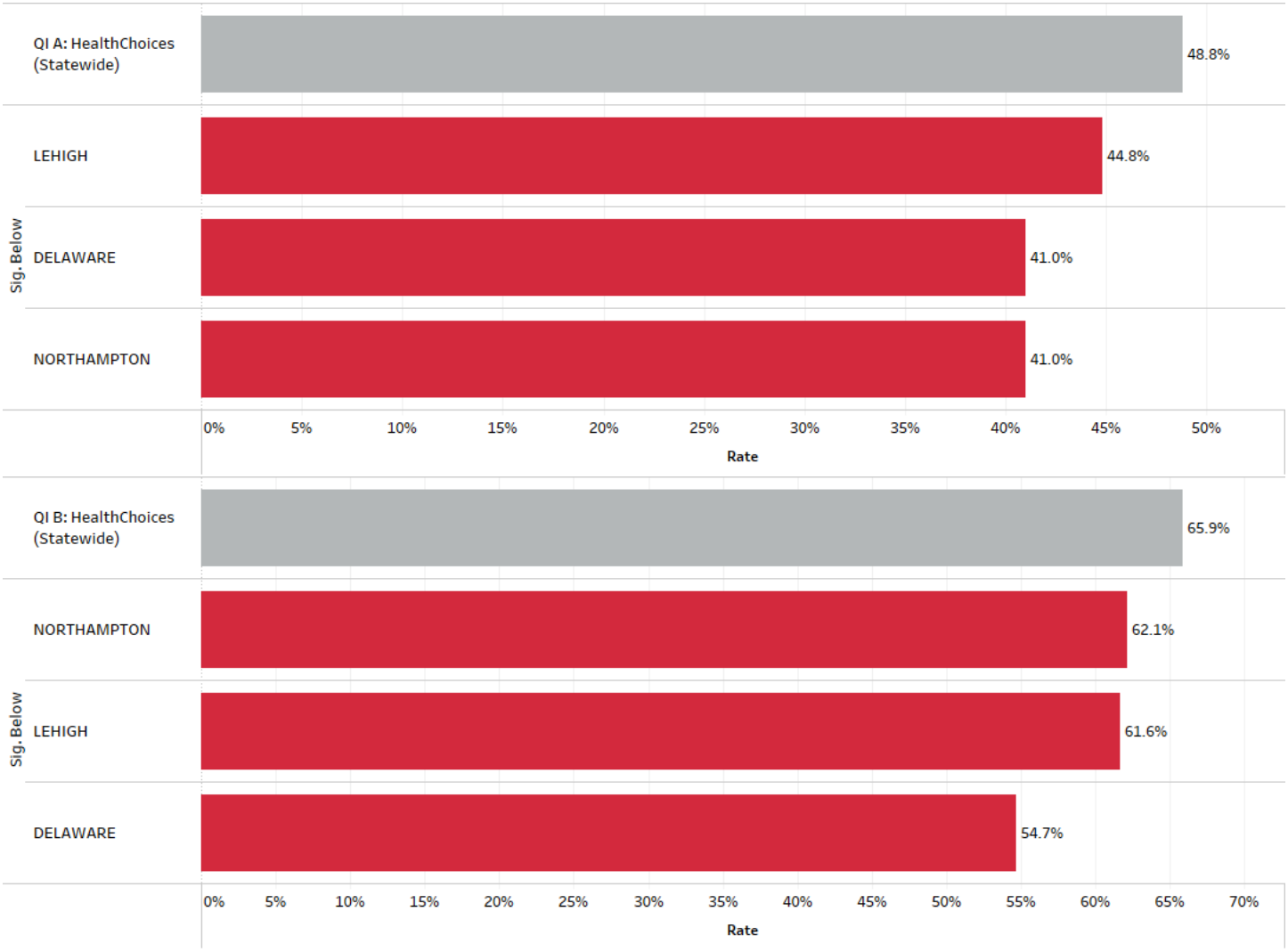


Figure 2.8: Statistically Significant Differences in MBH Contractor MY 2021 PA-Specific FUH Rates (All Ages). MBH Primary Contractor MY 2021 PA-specific FUH rates for all ages that are significantly different than HC BH (statewide) MY 2021 PA-specific FUH rates (all ages).

## III. Readmission Indicators

The results are presented at the BH-MCO and then Primary Contractor level. Year-to-year comparisons of MY 2021 to MY 2020 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the *Z* score. Statistically significant difference (SSD) at the 0.05 level between groups is noted, as well as the Percentage Point Difference (PPD) between the rates.

Individual rates were also compared to the categorical average. Rates statistically significantly above or below the average are indicated.

Lastly, aggregate rates were compared to the OMHSAS-designated PM goal of 11.75%. Individual BH-MCO and Primary Contractor rates are *not* required to be statistically significantly below 11.75% in order to meet the PM goal (**Table 2.5**).

Table 2.5: MY 2021 REA Readmission Indicators

| | MY 2021 | | | | | | MY 2021 Rate Comparison to MY 2020 | |
|---|---|---|---|---|---|---|---|---|
| | | | | 95% CI | | | | |
| Measure[1,2] | (N) | (D) | % | Lower | Upper | MY 2020 % | PPD | SSD |
| **Inpatient Readmission** | | | | | | | | |
| Statewide | 6151 | 46438 | **13.2%** | 12.9% | 13.6% | 13.6% | -0.3 | NO |
| Magellan | 1158 | 8293 | **14.0%** | 13.2% | 14.7% | 15.6% | -1.6 | YES |
| Bucks | 187 | 1416 | **13.2%** | 11.4% | 15.0% | 13.9% | -0.7 | NO |
| Cambria | 53 | 612 | **8.7%** | 6.4% | 11.0% | 15.3% | -6.7 | YES |
| Delaware | 224 | 1562 | **14.3%** | 12.6% | 16.1% | 15.7% | -1.4 | NO |
| Lehigh | 289 | 1736 | **16.6%** | 14.9% | 18.4% | 17.5% | -0.8 | NO |
| Montgomery | 257 | 1944 | **13.2%** | 11.7% | 14.8% | 15.4% | -2.2 | NO |
| Northampton | 148 | 1023 | **14.5%** | 12.3% | 16.7% | 15.1% | -0.6 | NO |

[1] The OMHSAS-designated performance measure goal is a readmission rate at or below 11.75%.
[2] Due to rounding, a PPD value may slightly diverge from the difference between the MY 2021 and MY 2020 rates.
MY: measurement year; REA: Readmission within 30 Days of Inpatient Psychiatric Discharge; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

**Figure 2.9** is a graphical representation of the MY 2021 readmission rates for MBH and its associated Primary Contractors. The orange line represents the MCO average.

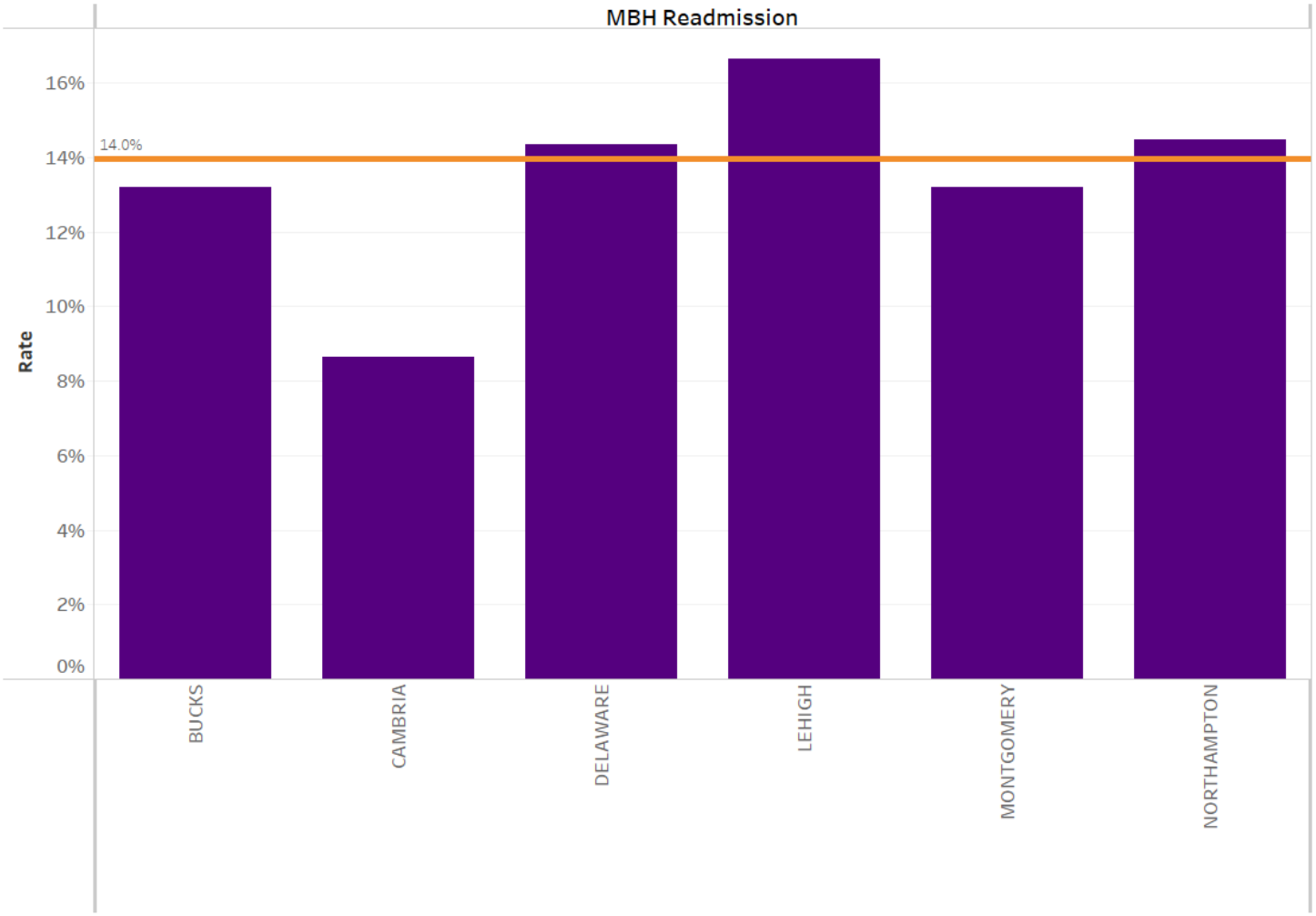


Figure 2.9: MY 2021 REA Rates for MBH Primary Contractors.

**Figure 2.10** shows the HC BH (statewide) readmission rate and the individual MBH Primary Contractors that performed statistically significantly higher (red) or lower (blue) than the HC BH statewide rate.

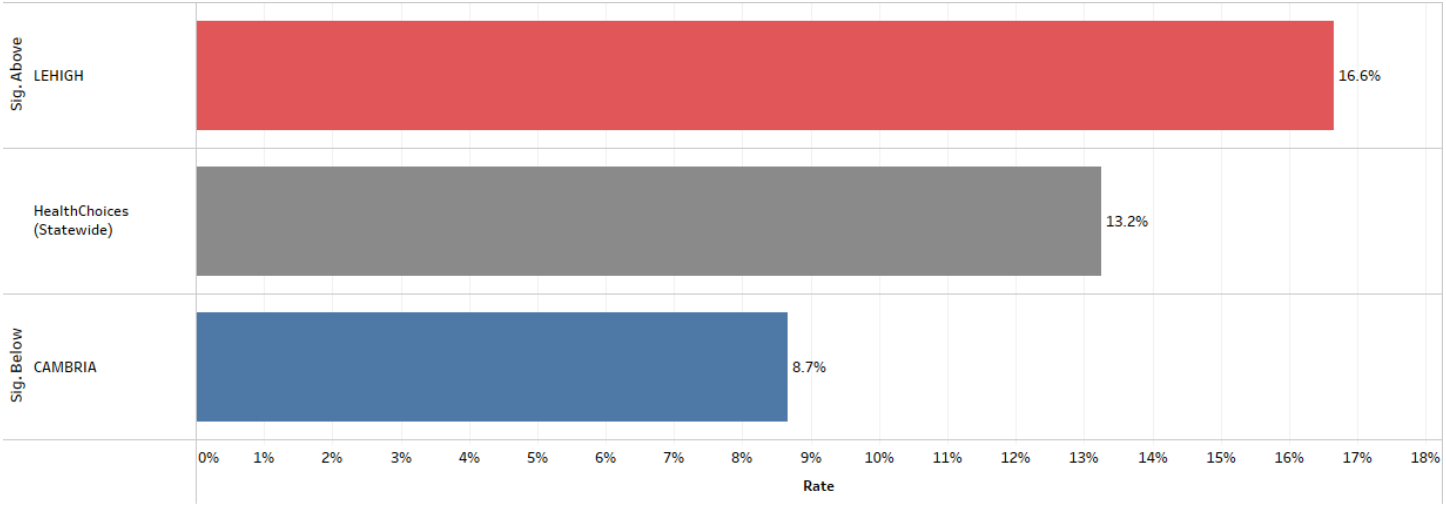


Figure 2.10: Statistically Significant Differences in MBH Primary Contractor MY 2021 REA Rates (All Ages). MBH Primary Contractor MY 2021 REA rates for all ages that are statistically significantly different than HC BH (statewide) MY 2021 REA rates (all ages).

## Recommendations

There were no changes to the measures from MY 2020 to MY 2021 that impact reporting integrity. That said, efforts should continue to be made to improve FUH performance, particularly for those BH-MCOs that performed below the HC BH statewide rate. The following are recommendations that are informed by the MY 2021 review:

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2021, which included actions taken as part of the previous PIP cycle, to promote continuous quality improvement with regard to timely follow-up care after psychiatric hospitalization. The information contained in this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. BH-MCOs are expected to demonstrate meaningful improvement in BH follow-up rates in the next few years as a result of their interventions. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at improving BH follow-up. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to receiving follow-up care and then implement action and monitoring plans to further increase their rates.
- It is essential to ensure that improvements are consistent, sustained across MYs, and applicable to all groups. As previously noted, although not enumerated in this report, further stratified comparisons such as Medicaid Expansion versus non-Medicaid Expansion were carried out in a separate 2022 (MY 2021) FUH Rates Report produced by the EQRO and made available to BH-MCOs in an interactive Tableau workbook. BH-MCOs and Primary Contractors should review their data mechanisms to accurately identify this population. Previous recommendations still hold. For example, it is important for BH-MCOs and Primary Contractors to analyze performance rates by racial and ethnic categories and to target the populations where these racial and ethnic disparities may exist. The BH-MCOs and Primary Contractors should continue to focus interventions on populations that exhibit lower follow-up rates. Further, it is important to examine regional trends in disparities. Possible reasons for racial-ethnic disparities include access, cultural competency, and community factors; these and other drivers should be evaluated to determine their potential impact on performance. The aforementioned 2022 (MY 2021) FUH Rates Report is one source BH-MCOs can use to investigate potential health disparities in FUH.
- Cambria stood out in MY 2021 for its statistically significant decrease in FUH among children aged 6-17 while at the same time significantly improving (decreasing) its REA rate. BH-MCOs and Primary Contractors are encouraged to review the 2022 (MY 2021) FUH Rates Report in conjunction with the corresponding 2022 (MY 2021) Inpatient Psychiatric Readmission (REA) Rates Report. The BH-MCOs and Primary Contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission in less than 30

days to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.

Continued efforts should be made to improve performance with regard to Readmission Within 30 Days of Inpatient Psychiatric Discharge, particularly for those BH-MCOs and Primary Contractors that did not meet the performance goal, and/or performed below the HC BH statewide rate.

MY 2021 saw a slight decrease (improvement) for the MCO in readmission rates after psychiatric discharge, although this decrease was not statistically significant. MBH's readmission rates after psychiatric discharge for the Medicaid managed care (MMC) population remains above 11.75%, the statewide maximum goal (and statistically significantly above the HC BH statewide average for one contractor, Lehigh, while only Cambria fell below 11.75%). As a result, many recommendations previously made remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted and the past PIP cycle, the recommendations may assist in future discussions.

In response to the 2021 study, the following are recommendations for improving (reducing) readmission rates after psychiatric discharge:

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2021 to promote continuous quality improvement with regard to mental health discharges that result in a readmission. The information contained within this study should be used to further develop strategies for decreasing the likelihood that at-risk members will be readmitted. In 2020, the BH-MCOs concluded a PIP that focused on improving transitions to ambulatory care from inpatient psychiatric services. A new PIP starting in 2021 builds on the previous PIP by, among other things, including a performance indicator that measures MH-related readmissions within 30 days of a discharge for SUD. BH-MCOs are expected to bring about meaningful improvement in BH readmission rates for this subpopulation with comorbid BH conditions and for their HC BH members more generally. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at reducing BH readmissions. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to successful transition to ambulatory care after an acute inpatient psychiatric discharge and then implement action and monitoring plans to further decrease their rates of readmission.
- The BH-MCOs and Primary Contractors should continue to focus interventions on populations that exhibit higher readmission rates (e.g., urban populations). Comparisons among demographic groups were carried out in a separate 2022 (MY 2021) REA Rates Report produced by the EQRO which is being made available to BH MCOs in an interactive Tableau workbook.
- BH-MCOs and Primary Contractors are encouraged to review the 2022 (MY 2021) REA Rates Report in conjunction with the aforementioned 2022 (MY 2021) FUH Rates Report. The BH-MCOs and Primary Contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission within 30 days to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.
- Cambria County was notable in its statistically significant decrease in readmissions. Other Primary Contractors in MBH's network may be able to draw insights from its success in MY 2021.

# III: Compliance with Medicaid Managed Care Regulations

## Objectives

This section of the EQR report presents a review by IPRO of the BH-MCO's compliance with the MMC structure and operations standards. In review year (RY) 2021, 67 PA counties participated in this compliance evaluation.

Operational reviews are completed for each HC-OE. The Primary Contractor, whether contracting with an OE arrangement or not, is responsible for their regulatory compliance to federal and state regulations and the HC BH PS&R Agreement compliance. The HC BH PS&R Agreement includes the Primary Contractor's responsibility for the oversight of the BH-MCO's compliance.

Bucks, Cambria, Delaware, Lehigh, Montgomery, and Northampton Counties hold contracts with MBH. All counties associated with MBH are individual Primary Contractors. **Table 3.1** shows the name of the HC-OE, the associated HC Primary Contractor(s), and the county(ies) encompassed by each Primary Contractor.

Table 3.1: MBH HealthChoices Oversight Entities, Primary Contractors and Counties

| HealthChoices Oversight Entity | Primary Contractor | County |
|---|---|---|
| Bucks County Behavioral Health | Bucks County | Bucks County |
| Behavioral Health of Cambria County (BHoCC) | Cambria County | Cambria County |
| Delaware County – DelCare Program | Delaware County | Delaware County |
| Lehigh County HealthChoices | Lehigh County | Lehigh County |
| Montgomery County Behavioral Health | Montgomery County | Montgomery County |
| Northampton County HealthChoices | Northampton County | Northampton County |

MBH: Magellan Behavioral Health.

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of MBH by OMHSAS monitoring staff within the past 3 review years (RYs 2021, 2020, and 2019). These evaluations are performed at the BH-MCO and Primary Contractor levels, and the findings are reported in OMHSAS's PEPS Review Application for 2021. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HC BH Program contract are documented in the RAI. If the Readiness Review occurred within the 3-year time frame under consideration, the RAI was provided to IPRO. For those Primary Contractors and BH-MCOs that completed their Readiness Reviews outside of the current 3-year time frame, the Readiness Review substandards were deemed as complete. As necessary, the HC BH PS&R are also used.

## Description of Data Obtained

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2021 and entered into the PEPS Application as of March 2022 for RY 2021. Information captured within the PEPS Application informs this report. The PEPS Application is a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each BH-MCO. Within each standard, the PEPS Application specifies the substandards or items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area in which to collect or capture additional reviewer comments. Based on the PEPS Application, an BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations ("categories"), as well as against related supplemental OMHSAS-specific PEPS substandards that are part of OMHSAS's more rigorous monitoring criteria.

At the implementation of the PEPS Application in 2004, IPRO evaluated the standards in the PEPS Application and created a crosswalk to pertinent BBA regulations. For standards with substandards, all of the substandards within the standard informed the compliance determination of the corresponding BBA category. In 2009, as requested by OMHSAS, IPRO conducted a re-assessment of the crosswalk to distinguish the substandards required for fulfilling BBA

requirements and those that are supplemental (i.e., state-specific) as part of OMHSAS's ongoing monitoring. In the amended crosswalk, the supplemental substandards no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS substandards concerning first-level complaints and grievances inform the compliance determination of the BBA categories relating to federal and state grievance systems standards. All of the PEPS substandards concerning second-level complaints and previously second-level grievances are considered OMHSAS-specific Substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category.

In accordance with the updates to the CMS EQRO Protocols released in late 2019,[21] IPRO updated the substandards crosswalk to reflect the changes to the organization and content of the relevant BBA provisions. The CMS updates included modifications to the BBA provisions, which are now required for reporting. The standards that are subject to EQR review are contained in Title 42 CFR 438, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E. In addition, findings for RY 2021 are presented here under the new rubric of the three "CMS sections": Standards, Including Enrollee rights and protections, Quality assessment and performance improvement (QAPI) program, and Grievance system. Substandard tallies for each category and section roll-up were correspondingly updated.

From time to time, standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions or changes to State standards. Standards or substandards that are introduced or retired are done so following the rotating 3-year schedule for all five BH-MCOs. This may, in turn, change the category tally of standards from one reporting year to the next. In 2019 (RY 2018), two Contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific.

As was done for prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The review findings for selected OMHSAS-specific Substandards are reported in **Appendix C**. The RY 2021 crosswalks of PEPS substandards to pertinent BBA regulations and to pertinent OMHSAS-specific PEPS substandards can be found in **Appendix A** and **Appendix B**, respectively.

Because OMHSAS's review of the Primary Contractors and their subcontracted BH-MCOs occurs over a 3-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The 3-year period is alternatively referred to as the Active Review period. The PEPS substandards from RY 2021, RY 2020, and RY 2019 provided the information necessary for the 2021 assessment. Those triennial standards not reviewed through the PEPS system in RY 2021 were evaluated on their performance based on RY 2020 and/or RY 2019 determinations, or other supporting documentation, if necessary. For those HC-OEs that completed their Readiness Reviews within the 3-year time frame under consideration, RAI Substandards were evaluated when none of the PEPS substandards crosswalked to a particular BBA category were reviewed.

For MBH, a total of 72 unique substandards were applicable for the evaluation of BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2021, 2020, and 2019). In addition, 18 OMHSAS-specific Substandards were identified as being related to, but are supplemental to, the BBA regulation requirements. Some PEPS substandards crosswalk to more than one BBA category, while each BBA category crosswalks to multiple substandards. In **Appendix C**, **Table C.1** provides a count of supplemental OMHSAS-specific Substandards that are not required as part of BBA regulations but are reviewed within the 3-year cycle to evaluate the BH-MCO and the associated Primary Contractor against other state-specific Structure and Operations Standards.

**Table 3.2** tallies the PEPs Substandard reviews used to evaluate the BH-MCO compliance with the BBA regulations and includes counts of the substandards that came under active review during each year of the current period (RYs 2019–2021). Substandard counts under RY 2021 comprised annual and triennial substandards. Substandard counts under RYs 2020 and 2019 comprised only triennial substandards. By definition, only the last review of annual substandards is

counted in the 3-year period. Because substandards may crosswalk to more than one category, the total tally of substandard reviews in **Table 3.2**, 94, differs from the unique count of substandards that came under active review (72).

Table 3.2: Tally of Substandards Pertinent to BBA Regulations Reviewed for MBH

| BBA Regulation | Evaluated PEPS Substandards[1] | | PEPS Substandards Under Active Review[2] | | |
|---|---|---|---|---|---|
| | Total | NR | 2021 | 2020 | 2019 |
| CMS EQR Protocol 3 "sections": Standards, Including enrollee rights and protections | | | | | |
| Assurances of adequate capacity and services (Title 42 CFR § 438.207) | 5 | - | 5 | - | - |
| Availability of Services (Title 42 CFR § 438.206, Title 42 CFR § 10(h)) | 24 | - | 16 | 6 | 2 |
| Confidentiality (Title 42 CFR § 438.224) | 1 | - | 1 | - | - |
| Coordination and continuity of care (Title 42 CFR § 438.208) | 2 | - | - | - | 2 |
| Coverage and authorization of services (Title 42 CFR Parts § 438.210(a–e), Title 42 CFR § 441, Subpart B, and § 438.114) | 4 | - | 2 | - | 2 |
| Health information systems (Title 42 CFR § 438.242) | 1 | - | 1 | - | - |
| Practice guidelines (Title 42 CFR § 438.236) | 6 | - | 4 | - | 2 |
| Provider selection (Title 42 CFR § 438.214) | 3 | - | - | 3 | - |
| Subcontractual relationships and delegation (Title 42 CFR § 438.230) | 8 | - | 8 | - | - |
| CMS EQR Protocol 3 "sections": Quality assessment and performance improvement (QAPI) program | | | | | |
| Quality assessment and performance improvement program (Title 42 CFR § 438.330) | 26 | - | 26 | - | - |
| CMS EQR Protocol 3 "sections": Grievance system | | | | | |
| Grievance and appeal systems (Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424) | 14 | - | 2 | - | 12 |
| **Total** | **94** | **-** | **65** | **9** | **20** |

[1] The total number of substandards required for the evaluation of Primary Contractor/BH-MCO compliance with the BBA regulations. Any PEPS substandards not reviewed indicate substandards that were deemed not applicable to the Primary Contractor /BH-MCO.
[2] The number of substandards that came under active review during the cycle specific to the review year. Because substandards may crosswalk to more than one category, the total tally of substandard reviews, 94, differs from the unique count of substandards that came under active review (72).
RY: review year; BBA: Balanced Budget Act; MBH: Magellan Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: substandards not reviewed; NR: substandards not reviewed; CMS: Centers for Medicare and Medicaid Services; EQR: external quality review; CFR: Code of Federal Regulations.

## Determination of Compliance

To evaluate Primary Contractor/BH-MCO compliance with individual provisions, IPRO grouped the required and relevant monitoring substandards by provision (category) and evaluated the Primary Contractors' and BH-MCO's compliance status with regard to the PEPS substandards. Each substandard was assigned a value of "met," "partially met," or "not met" in the PEPS Application submitted by PA. If a substandard was not evaluated for a particular Primary Contractor/BH-MCO, it was assigned a value of "not reviewed." Compliance with the BBA provisions was then determined based on the aggregate results across the 3-year period of the PEPS items linked to each provision. If all items were met, the Primary Contractor/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the Primary Contractor/BH-MCO was evaluated as partially compliant. If all items were not met, the Primary Contractor/BH-MCO was evaluated as non-compliant. A value of not applicable (N/A) was assigned to provisions for which a compliance review was not required. A value of null was assigned to a provision when none of the existing PEPS substandards directly covered the items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results within a given category were aggregated to arrive at a summary compliance status for the category. For example, compliance findings relating to provider network mix and capacity are summarized under Assurances of adequate capacity and services, *Title 42 CFR § 438.207*.

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the

three sections set out in the BBA regulations and described in "Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."[22] Under each general section heading are the individual regulatory categories appropriate to those headings. IPRO's findings are therefore organized under Standards, Including Enrollee Rights and Protections, Quality Assessment and Performance Improvement (QAPI) Program, and Grievance System.

This format reflects the goal of the review, which is to gather sufficient foundation for IPRO's required assessment of the Primary Contractor/BH-MCO's compliance with BBA regulations as an element of the analysis of their strengths and weaknesses. In addition, this level of analysis avoids any redundancy with the detailed level of review found in the PEPS documents.

## Findings

Seventy-two (72) unique PEPS substandards were used to evaluate MBH and its Primary Contractors' compliance with BBA regulations in RY 2021.

### Standards, Including Enrollee Rights and Protections

The general purpose of the regulations included in this section is to ensure that each Primary Contractor/BH-MCO has written policies regarding enrollee rights, complies with applicable federal and state laws that pertain to enrollee rights, and that the Primary Contractor/BH-MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees. **Table 3.3** presents the MCO and Primary Contractor substandard findings by categories.

Table 3.3: Compliance with Standards, Including Enrollee Rights and Protections

| Federal Category and CFR reference | Category Substandard Count | MCO Compliance Status | Primary Contractor | Substandard Status | | |
|---|---|---|---|---|---|---|
| | | | | Fully Compliant | Partially Compliant | Not Compliant |
| Assurances of adequate capacity and services Title 42 CFR § 438.207 | 5 | Compliant | All MBH Primary Contractors | 1.1, 1.2, 1.4, 1.5, 1.6 | - | - |
| Availability of Services Title 42 CFR § 438.206, Title 42 CFR § 10(h) | 24 | Compliant | All MBH Primary Contractors | 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 23.1, 23.2, 23.3, 23.4, 23.5, 24.1, 24.2, 24.3, 24.4, 24.5, 24.6, 28.1, 28.2, 93.1, 93.2, 93.3, 93.4 | - | - |
| Confidentiality Title 42 CFR § 438.224 | 1 | Compliant | All MBH Primary Contractors | 120.1 | - | - |
| Coordination and continuity of care Title 42 CFR § 438.208 | 2 | Compliant | All MBH Primary Contractors | 28.1, 28.2 | - | - |
| Coverage and authorization of services Title 42 CFR Parts § 438.210(a–e), Title 42 CFR § 441, Subpart B, and § | 4 | Partial | All MBH Primary Contractors | 28.1, 28.2, 72.2 | 72.1 | - |

| Federal Category and CFR reference | Category Substandard Count | MCO Compliance Status | Primary Contractor | Substandard Status | | |
|---|---|---|---|---|---|---|
| | | | | Fully Compliant | Partially Compliant | Not Compliant |
| 438.114 | | | | | | |
| Health information systems Title 42 CFR § 438.242 | 1 | Compliant | All MBH Primary Contractors | 120.1 | - | - |
| Practice guidelines Title 42 CFR § 438.236 | 6 | Compliant | All MBH Primary Contractors | 28.1, 28.2, 93.1, 93.2, 93.3, 93.4 | - | - |
| Provider selection Title 42 CFR § 438.214 | 3 | Compliant | All MBH Primary Contractors | 10.1, 10.2, 10.3 | - | - |
| Subcontractual relationships and delegation Title 42 CFR § 438.230 | 8 | Compliant | All MBH Primary Contractors | 99.1, 99.2, 99.3, 99.4, 99.5, 99.6, 99.7, 99.8 | - | - |

MCO: managed care organization; CFR: Code of Federal Regulations; MBH: Magellan Behavioral Health.

There are nine (9) categories within Standards, Including Enrollee Rights and Protections. MBH was compliant with 8 categories and partially compliant with 1 category.

For this review, 54 PEPS substandards were crosswalked to categories within Compliance with Standards, Including Enrollee Rights and Protections. MBH and its Primary Contractors were reviewed on all 54 substandards. MBH and its Primary Contractors were compliant in 53 instances and partially compliant in 1 instance. Some PEPS substandards apply to more than one BBA category. As a result, one partially compliant or non-compliant rating for an individual PEPS substandard could result in several BBA categories with partially compliant or non-compliant ratings.

### Coverage and Authorization of Services

MBH was partially compliant with Coverage and Authorization of Services due to partial compliance with Substandard 1 within PEPS Standard 72 (RY 2021).

**Standard 72:** Denials or reduction of services are provided, in writing, to the member, parent/custodian of a child/adolescent, and/or county Children and Youth agency for children in substitute care. [E.3), p.39 and Appendix AA, Attachments 2a, 2b, 2c, and 2d].

**Substandard 1**: Denial notices are issued to members according to required timeframes and use the required template language.

### Quality Assessment and Performance Improvement Program

The general purpose of the regulations included under this subpart is to ensure that all services available under PA's MMC program, the HC Program, are available and accessible to MCO enrollees. The PEPS documents include an assessment of the Primary Contractors/BH-MCO's compliance with regulations found in Subpart D. **Table 3.4** presents the findings by categories consistent with the regulations.

Table 3.4: Compliance with Quality Assessment and Performance Improvement Program

| Federal Category and CFR reference | Category Substandard Count | MCO Compliance Status | Primary Contractor | Substandard Status | | |
|---|---|---|---|---|---|---|
| | | | | Fully Compliant | Partially Compliant | Not Compliant |
| Quality assessment and performance improvement program Title 42 CFR § 438.330 | 26 | Compliant | All MBH Primary Contractors | 91.1, 91.2, 91.3, 91.4, 91.5, 91.6, 91.7, 91.8, 91.9, 91.10, 91.11, 91.12, 91.13, 91.14, 91.15, 93.1, 93.2, 93.3, 93.4, 98.1, 98.2, 98.3, 104.1, 104.2, 104.3, 104.4 | - | - |

MCO: managed care organization; MBH: Magellan Behavioral Health; CFR: Code of Federal Regulations.

For this review, 26 substandards were crosswalked to Quality Assessment and Performance Improvement Program. All 26 substandards were reviewed for MBH and its Primary Contractors. MBH and its Primary Contractors were compliant with all 26 substandards.

### Grievance System

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances. The PEPS documents include an assessment of the Primary Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 3.5** presents the findings by categories consistent with the regulations.

Table 3.5: Compliance with Grievance System

| Federal Category and CFR reference | Category Substandard Count | MCO Compliance Status | Primary Contractor | Substandard Status | | |
|---|---|---|---|---|---|---|
| | | | | Fully Compliant | Partially Compliant | Not Compliant |
| Grievance and appeal systems Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424 | 14 | Partial | All MBH Primary Contractors | 68.1, 68.2, 68.3, 68.7, 71.2, 71.3, 71.4, 71.7, 71.9, 72.2 | 68.4, 68.9, 71.1, 72.1 | - |

MCO: managed care organization; MBH: Magellan Behavioral Health; CFR: Code of Federal Regulations.

For this review, 14 substandards were crosswalked to Grievance System. All 14 substandards were reviewed for MBH and its Primary Contractors. MBH and its Primary Contractors were compliant with 10 substandards and partially compliant with 4 substandards.

### Grievance and Appeal Systems

MBH was partially compliant with Grievance and Appeal Systems due to partial compliance with 2 substandards of PEPS Standard 68 (RY 2019), 1 substandard of PEPS Standard 71 (RY 2019), and 1 substandard of PEPS Standard 72 (RY 2021).

**Standard 68:** The Complaint and Fair Hearing processes, procedures and Member rights related to the processes are made known to Members, BH-MCO staff and the provider network through manuals, training, handbooks, etc.

**Substandard 4:** Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).

**Substandard 9:** Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review.

**Standard 71:** The Grievance and Fair Hearing processes, procedures and Member rights related to the processes are made known to Members, BH-MCO staff and the provider network through manuals, training, handbooks, etc.

**Substandard 1:** Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: 1. Internal, 2. External, 3. Expedited, 4. Fair Hearing.

**Standard 72:** See Standard description and determination of compliance under Coverage and Authorization of Services.

**Substandard 1:** See substandard description and determination of compliance under Coverage and Authorization of Services.

# IV: Validation of Network Adequacy

## Objectives

As set forth in *Title 42 CFR §438.358*, validation of network adequacy is a mandatory EQR activity. The purpose of this section is to assess the BH-MCO's network adequacy in accordance with standards established under *Title 42 CFR § 438.68(b) (1)(iii)* and *457.1218*.

## Description of Data Obtained

For the 2021 review year, the BH-MCO's network adequacy was assessed based on compliance with certain federal and OMHSAS-specific standards that were crosswalked to standards falling directly or indirectly under *Title 42 CFR § 438.68(b) (1)(iii)* and *457.1218*. Compliance status was determined as part of the larger assessment of compliance with MMC regulations. As of MY 2021, EQR validation protocols for assessing network adequacy had not been published by CMS. Since the publication of the *2020 Medicaid and CHIP Managed Care Final Rule*, OMHSAS is actively reviewing its network adequacy monitoring program to ensure all relevant requirements are covered in the annual validation activity going forward. For BH, those requirements include: quantitative network adequacy standards, ensuring timely access to services, ensuring provider accessibility, allowing access to out-of-network providers, documenting an MCO's capacity to serve all enrollees, and adhering to the 2008 Mental Health Parity and Addictions Equity Act (MHPAEA) regulations on treatment limitations.[23]

## Findings

**Table 4.1** describes the RY 2021 compliance status of MBH with respect to network adequacy standards that were in effect in 2021. Definitions for most standards may be found in **Section III**, Compliance with Medicaid Managed Care Regulations. The following standards are specific to validation of network adequacy (any substandards for which the MCO is not fully compliant are defined further below):

**Standard 11:** BH-MCO has conducted orientation for new providers and ongoing training for network.

**Standard 59:** BM-MCO has implemented public education and prevention programs, including BH educational materials.

**Standard 78:** Evidence exists of the County's oversight of functions and activities delegated to the BH-MCO including: a. County Table of Organization showing a clear organization structure for oversight of BH-MCO functions. b. In the case of a multi-county contract, the Table of Organization shows a clear relationship among and between Counties' management structures, as it relates to the BH-MCO oversight. c. The role of the Single County Authority (SCA) in oversight is clear in the oversight structure. d. Meeting schedules and attendee minutes reflect County oversight of the BH-MCO (e.g., adequate staff with appropriate skills and knowledge that regularly attend meetings and focus on monitoring the contract and taking appropriate action, such as CAPs. e. Documentation of the County's reviews and/or audits of quality and accuracy of the major BH-MCO functions, including: 1) Care Management, 2) Quality Assurance (QA), 3) Financial Programs, 4) MIS, 5) Credentialing, 6) Grievance System, 7) Consumer Satisfaction, 8) Provider Satisfaction, 9) Network Development, Provider Rate Negotiation, and 10) Fraud, Waste, and Abuse (FWA).

**Standard 100:** Utilization Management and Quality Management: Provider Satisfaction: The Primary Contractor, either directly or via a BH-MCO or other subcontractor, must have systems and procedures to assess provider satisfaction with network management. The systems and procedures must include, but not be limited to, an annual provider satisfaction survey. Areas of the survey must include claims processing, provider relations, credentialing, prior authorization, service management and quality management.

Table 4.1: Compliance with Standards Related to Network Adequacy

| Standard Description | Substandard Count | MCO Compliance Status | Primary Contractors | Substandard Status | | |
|---|---|---|---|---|---|---|
| | | | | Fully Compliant | Partially Compliant | Not Compliant |
| Standard 1 | 7 | Compliant | All MBH Primary Contractors | 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7 | - | - |
| Standard 10 | 3 | Compliant | All MBH Primary Contractors | 10.1, 10.2, 10.3 | - | - |
| Standard 11 | 3 | Compliant | All MBH Primary Contractors | 11.1, 11.2, 11.3 | - | - |
| Standard 23 | 5 | Compliant | All MBH Primary Contractors | 23.1, 23.2, 23.3, 23.4, 23.5 | - | - |
| Standard 24 | 6 | Compliant | All MBH Primary Contractors | 24.1, 24.2, 24.3, 24.4, 24.5, 24.6 | - | - |
| Standard 59 | 1 | Compliant | All MBH Primary Contractors | 59.1 | - | - |
| Standard 78 | 5 | Partial | Bucks, Montgomery (78.5 N/A) | 78.1, 78.2, 78.3, 78.4 | - | - |
| | | | Delaware (78.5 N/A) | 78.2, 78.3 | 78.1 | - |
| | | | Lehigh, Northampton | 78.1, 78.2, 78.3, 78.4, 78.5 | - | - |
| Standard 91 | 15 | Compliant | All MBH Primary Contractors | 91.1, 91.2, 91.3, 91.4, 91.5, 91.6, 91.7, 91.8, 91.9, 91.10, 91.11, 91.12, 91.13, 91.14, 91.15 | - | - |
| Standard 93 | 4 | Compliant | All MBH Primary Contractors | 93.1, 93.2, 93.3, 93.4 | - | - |
| Standard 99 | 8 | Compliant | All MBH Primary Contractors | 99.1, 99.2, 99.3, 99.4, 99.5, 99.6, 99.7, 99.8 | - | - |
| Standard 100 | 1 | Compliant | All MBH Primary Contractors | 100.1 | - | - |

MCO: managed care organization; MBH: Magellan Behavioral Health; CFR: Code of Federal Regulations.

For this review, 58 substandards were crosswalked to Network Adequacy. All 58 substandards were reviewed for MBH and its Primary Contractors. MBH and these Primary Contractors were compliant with 57 substandards and partially compliant with 1 substandard.

MBH was partially compliant with Standard 78 due to partial compliance with one substandard (RY 2019).

**Standard 78** (see description above)

**Substandard 1:** Updated County Table of Organization - Evidence of sufficient staff

# V: Quality Studies

## Objectives

The purpose of this section is to describe quality studies performed in 2021 for the HC population. The studies are included in this report as optional EQR activities that occurred during the Review Year.[24]

### Integrated Community Wellness Centers

In 2019, PA DHS made the decision to discontinue participation in the CCBHC Demonstration but to continue and build on the CCBHC model in a PA DHS-administered Integrated Community Wellness Centers (ICWC) program under an MMC agreement with CMS. The purpose of the CCBHC Demonstration was to develop and test an all-inclusive (and all-payer) prospective payment system model for community clinics to integrate behavioral and physical health care services in a more seamless manner. The model is centered on the provision of nine core services. Crisis services, BH screening, assessment and diagnosis, treatment planning, and outpatient mental health and substance use services, along with outpatient clinic primary care screening and monitoring, are provided or managed directly by the ICWC clinics. The other services, including targeted case management, peer support, psychiatric rehabilitation services, and intensive community-based mental health care to members of the armed forces and veterans may be provided through a contract with a Designated Collaborating Organization (DCO). To receive CCBHC certification, clinics also had to provide a minimum set of evidence-based practices (EBP), which was selected based on community needs assessments and centered on recovery-oriented care and support for children, youth, and adults. Under ICWC, the same nine core services of the CCBHC model are provided under PA's HC MMC program using a similar bundled payment arrangement with clinics certified to participate as ICWC clinics. For the first year of ICWC, 2020, the original seven clinics—Berks Counseling Center (located in Reading, PA), CenClear (with a clinic site in Clearfield, PA, and in Punxsutawney, PA), the Guidance Center (located in Bradford, PA), Northeast Treatment Centers (located in Philadelphia, PA), Pittsburgh Mercy (located in Pittsburgh, PA), and Resources for Human Development (located in Bryn Mawr, PA)—were invited to participate in the new program.

## Description of Data Obtained

Like CCBHC, ICWC features a process measure dashboard, hosted by the EQRO. Clinics enter monthly, quarterly, and year-to-date (YTD) data into a REDCap® project which feeds, on a weekly basis, a server-based Tableau workbook where clinics are able to monitor progress on the implementation of their ICWC model. Using the Dashboard, clinics in 2021 tracked and reported on clinical activities in a range of quality domains reflecting the priorities of the initiative: clinic membership, process, access and availability, engagement, evidence-based practices, and client satisfaction. The Tableau workbook also featured a comparative display that showed clinic and statewide results on each process measure.

## Findings

In 2021, the number of individuals receiving at least one core service jumped to 22,690 from just over 17,700 in 2020. The unweighted average (across all the clinics) number of days until initial evaluation increased to 10.8 days from 8 days in 2020. In the area of depression screening and follow-up, just over 90% of positive screenings resulted in the documentation of a follow-up plan the same day. More than 5,400 individuals within the ICWC program received drug and alcohol outpatient or intensive outpatient treatment during the period.

Process measures reflect important progress in increasing both the access and quality of community-based care for individuals with BH conditions, but the ICWC quality measures are designed to more meaningfully measure the impact of these efforts. Under the CMS-approved ICWC preprint, a subset of the CCBHC measures is reported to CMS on an annual CY basis, along with HEDIS Follow-Up After High Intensity Care for Substance Use Disorder (FUI). **Table 5.1** summarizes how well the ICWC clinics performed on quality measures compared to applicable performance targets and national benchmarks.

Table 5.1: ICWC Quality Performance Compared to Targets and National Benchmarks

| Measure | ICWC Weighted Average | Comparison | | |
|---|---|---|---|---|
| | | ICWC CY 2021 Performance Target | National Benchmark | Benchmark Description |
| Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 7 day | 10.0% | N/A (Improvement over baseline) | N/A | Between the 5th and 10th percentile of the HEDIS 2022 Quality Compass |
| Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) – 30 day | 19.3% | N/A (Improvement over baseline) | N/A | Below the 5th percentile of the HEDIS 2022 Quality Compass |
| Follow-Up Care for Children Prescribed ADHD Medication (ADD) - Initiation | 61.1% | 80.2% | N/A | Above the 95th percentile of the HEDIS 2022 Quality Compass |
| Follow-Up Care for Children Prescribed ADHD Medication (ADD) – Continuation and Maintenance | 60.9% | 89.6% | N/A | Between the 75th and 90th percentile of the HEDIS 2022 Quality Compass |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 7 day | 22.3% | 26.7% | N/A | Between the 90th and 95th percentile of the HEDIS 2022 Quality Compass |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 30 day | 34.8% | 38.8% | N/A | Between the 90th and 95th percentile of the HEDIS 2022 Quality Compass |
| Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 7 day | 100% | 53.4% | N/A | Above the 95th percentile of the HEDIS 2022 Quality Compass |
| Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 day | 100% | 64.2% | N/A | Above the 95th percentile of the HEDIS 2022 Quality Compass |
| Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18–64 - Initiation | 3.0% | 19.3% | N/A | Below the 5th percentile of the HEDIS 2022 Quality Compass |
| Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18–64 - Engagement | 17.0% | 28.2% | N/A | Between the 50th and 75th percentile of the HEDIS 2022 Quality Compass |
| Follow-Up After Hospitalization for Mental Illness, ages 18–64 (FUH-A) - 7 day | 9.0% | 30.2% | N/A | Below the 5th percentile of the HEDIS 2022 Quality Compass |
| Follow-Up After Hospitalization for Mental Illness, ages 18–64 (FUH-A) - 30 day | 18.0% | 41.6% | N/A | Below the 5th percentile of the HEDIS 2022 Quality Compass |
| Follow-Up After Hospitalization for Mental Illness, ages 6–17 (FUH-C) - 7 day | 27.1% | 43.8% | N/A | Between the 5th and 10th percentile of the HEDIS 2022 Quality Compass |
| Follow-Up After Hospitalization for Mental Illness, ages 6–17 (FUH-C) - 30 day | 23.1% | 55.6% | N/A | Below the 5th percentile of the HEDIS 2022 Quality Compass |
| Antidepressant Medication Management (AMM) - Acute | 63.0% | 48.8% | N/A | Between the 50th and 75th percentile of the HEDIS 2022 Quality Compass |

| Measure | ICWC Weighted Average | Comparison | | |
|---|---|---|---|---|
| | | ICWC CY 2021 Performance Target | National Benchmark | Benchmark Description |
| Antidepressant Medication Management (AMM) - Continuation | 37.0% | 89.5% | N/A | Between the 10th and 25th percentile of the HEDIS 2022 Quality Compass |
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) | 55.3% | 57.3% | N/A | Between the 25th and 50th percentile of the HEDIS 2022 Quality Compass |
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) | 74.9% | 85.0% | N/A | Between the 10th and 25th percentile of the HEDIS 2022 Quality Compass |
| Plan All-Cause Readmissions Rate (PCR) | 15.0% | 6.9% | N/A | HEDIS 2022 Quality Compass 50th percentile |
| Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C) | 56.0% | 16.2% | 14.3% | MIPS 2022 (eCQM) |
| Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A) | 32.6% | 26.3% | 28.8% | MIPS 2022 (eCQM) |
| Screening for Depression and Follow-Up Plan (CDF-BH) | 32.0% | 37.7% | 33.2% | MIPS 2022 (CQM) |
| Depression Remission at Twelve Months (DEP-REM-12) | 13.7% | N/A | 8.2% | MIPS 2022 (eCQM) |
| Body Mass Index (BMI) Screening and Follow-Up Plan | 43.1% | 51.0% | 45.0% | MIPS 2022 (eCQM) |
| Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH) | 58.0% | 64.5% | N/A | Between the 5th and 10th percentile of the HEDIS 2022 Quality Compass |
| Tobacco Use: Screening and Cessation Intervention (TSC) | 70.6% | 56.0% | 60.4% | MIPS 2021 (CQM) |
| Unhealthy Alcohol Use: Screening and Brief Counseling (ASC) | 67.0% | 51.1% | 68.4% | MIPS 2021 (CQM) |

ICWC: integrated community wellness center; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable; ADHD: attention deficit/hyperactivity disorder; MIPS: Merit-Based Incentive Pay System; eCQM: electronic clinical quality measure; CQM: clinical quality measure.

Quality measures where the ICWC clinics surpassed targets include: FUM, AMM (Acute), PCR, SRA-BH-C, SRA-A, TSC, and ASC.

# VI: 2021 Opportunities for Improvement – MCO Response

## Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each BH-MCO has effectively addressed the opportunities for improvement cited by IPRO in the 2021 (MY 2020) EQR annual technical report and in the 2022 (MY 2021) FUH All-Ages Goal Report.

The request for MCO response to the opportunities for improvement related to PEPS deficiencies was distributed in September 2022. The 2022EQR annual technical report is the 15th report to include descriptions of current and proposed interventions from each BH-MCO that address the prior year's deficiencies.

The BH-MCOs are required by OMHSAS to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses are reported consistently across the PA Medicaid BH-MCOs. These activities follow a longitudinal format and are designed to capture information relating to:

- follow-up actions that the BH-MCO has taken through June 30, 2022, to address each recommendation;
- future actions that are planned to address each recommendation;
- when and how future actions will be accomplished;
- the expected outcome or goals of the actions that were taken or will be taken; and
- the BH-MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the MCO responses submitted to IPRO in December 2022 to address partial and non-compliant PEPS standards findings, as well as any additional relevant documentation provided by the BH-MCO.

The request for MCO response to the opportunities for improvement related to MY 2021 underperformance in the HEDIS FUH All-Ages measures were distributed, along with the MY 2021 results, in January 2023. The Root Cause Analysis and Quality Improvement Plan form similarly provides for a standardized format for BH-MCOs to describe root causes of underperformance and propose a detailed quality improvement plan to address those factors, complete with a timeline of implementation-, monitoring-, and reporting activities. BH-MCOs submitted their responses by March 17, 2023, and the Primary Contractors submitted their responses by March 31, 2023.

## Quality Improvement Plan for Partial and Non-compliant PEPS Standards

All actions targeting opportunities for improvement with the structure and operational standards are monitored for effectiveness by OMHSAS. Based on the OMHSAS findings for RY 2020, MBH began to address opportunities for improvement related to compliance categories within the three CMS sections pertaining to compliance with MMC regulations. Within Compliance with Standards, Including Enrollee Rights and Protections, MBH was partially compliant with the following BBA categories: Assurances of Adequate Capacity and Services, Availability of Services, and Coverage and Authorization of Services. Within Quality Assessment and Performance Improvement Program, MBH was partially compliant within the same-named category. Within Compliance with Grievance System, MBH was partially compliant with Grievance and Appeal Systems. Proposed actions and evidence of actions taken by MBH were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring MBH into compliance with the relevant Standards.

**Table 6.1** presents MBH's responses to opportunities for improvement cited by IPRO in the 2021 (MY 2020) EQR annual technical report, detailing current and proposed interventions. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 6.1: MBH's Responses to Opportunities for Improvement

| Reference Number | Opportunity for Improvement | Date(s) of Follow-Up Action(s) Taken/Planned | MCO Response |
|---|---|---|---|
| Review of Compliance with Standards conducted by PA in reporting year (RY) 2019, RY 2020, and RY 2021 found MBH to be partially compliant with all three sections in CMS Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations. | | Date(s) of follow-up action(s) taken through 6/30/22/Ongoing/None | Address within each category accordingly. |
| | | Date(s) of future action(s) planned/None | Address within each category accordingly. |
| MBH 2022.01 | Within CMS EQR Protocol 3: Compliance with Standards, Including Enrollee Rights and Protections, MBH was partially compliant with two out of nine categories. The partially compliant categories are:<br><br>1) Assurances of Adequate Capacity and Services<br>2) Availability of Services<br>3) Coverage and Authorization of Services | Date(s) of follow-up action(s) taken through 6/30/22 | **Standard 1, Substandard 4: BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services).**<br><br>Magellan has a mechanism in place to address gaps in service and ensure members have timely access to services. See Magellan's Identification of Network Capacity and Gaps in Services Procedure. Gaps in network are reviewed in various County quality oversight committees. |
| | | Date(s) of follow-up action(s) taken through 6/30/22 | **Standard 1, Substandard 7: Confirm FQHC providers.**<br><br>Magellan is contracted with FQHC providers in all Counties. |
| | | Date(s) of follow-up action(s) taken through 6/30/22 | **Standard 23, Substandard 5: BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)**<br><br>The Written Translation report was updated in 2020 to include a breakdown by County of request. |
| | | Date(s) of follow-up action(s) taken through 6/30/22 | **Standard 72, Substandard 1: Denial notices are issued to members according to required timeframes and use the required template language.**<br><br>For all out-of-network provider denials, Magellan utilizes Denial Letter template 2b Standard Denial Template for requests that are approved other than requested. |

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| MBH 2022.02 | Within CMS EQR Protocol 3: Quality Assessment and Performance Improvement Program (QAPI), MBH was partially compliant with QAPI. | Date(s) of follow-up action taken through 6/30/22 | **<u>Standard 91, Substandard 5: The QM Work Plan outlines the specific activities related to coordination and interaction with other entities, including but not limited to, Physical Health MCO's (PH-MCO).</u>**<br><br>• For the 2018 Quality Work Plan, Indicator #17, Magellan outlines activities related to coordination and interaction with other entities, including CHC MCOs and PH-MCOs.<br>• For the 2019 Work Plan, because the earlier established goals were achieved, as part of the CQI process, Magellan adjusted the Objective for CHC and this is reflected now in the Quality Work Plan #68.<br>• In the 2020 Quality Work Plan, these include indicators 11, 12, 13, 15, 17, and 69.<br>• In the 2021 Quality Work Plan, these include indicators 11, 12, 13, 14, and 21.<br>• In the 2022 Quality Work Plan, these include indicators 10, 11, 12, 13, 29, and 58. |
| | | Date(s) of future action planned- Ongoing | Coordination and interaction with other entities is an annual activity. |
| | | Date(s) of follow-up action taken through 6/30/22 | **<u>Standard 91, Substandard 6: The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted.</u>**<br><br>• For the 2020 Quality Work Plan this is indicator # 24.<br>• For the 2021 Quality Work Plan this is indicator #21.<br>• For the 2022 Quality Work Plan this is indicator # 20. (Work Plans previously attached) |
| | | Date(s) of future action planned- Ongoing | Formalized collaborative efforts (joint studies) are an annual activity. |
| | | Date(s) of follow-up action taken through 6/30/22 | **<u>Standard 91, Substandard 10: The QM Work Plan includes monitoring activities conducted to evaluate the quality and performance of the provider network: Quality of individualized service plans and treatment planning Adverse incidents Collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance.</u>**<br><br>• For the 2019 Quality Work Plan this is indicator #16.<br>• For the 2020 Quality Work Plan this is indicator # 82. |

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| | | | • For the 2021 Quality Work Plan this is indicator # 73.<br>• For the 2022 Quality Work Plan this is indicator # 68.<br>(Work Plans previously attached) |
| | | Date(s) of future action planned- Ongoing | Monitoring activities to evaluate the quality and performance of the provider network is an annual activity. |
| | | Date(s) of follow-up action taken through 6/30/22 | **Standard 91, Substandard 11: The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO.**<br><br>Magellan has enhanced the Quality Work Plan to include specificity for provider experience and areas of survey focus and benchmarks from the previous review period in order to assess process.<br><br>• For the 2020 Quality Work Plan this is indicator # 25.<br>• For the 2021 Quality Work Plan this is indicator # 22.<br>• For the 2022 Quality Work Plan this is indicator # 21.<br>(Work Plans previously attached) |
| | | Date(s) of future action planned- Ongoing | The provider satisfaction survey is an annual activity. |
| | | Date(s) of follow-up action taken through 6/30/22 | **Standard 91, Substandard 14: The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the annual evaluation and any corrective actions required from previous reviews.**<br><br>The recommendation for the 2020 Quality Work Plan to include information on how previously issued Corrective Action Plans (CAP) are addressed was discussed during the 10/24/19 QIC meeting. As a result, a Work Plan item was added focusing on the monitoring of CAP activities.<br><br>• For the 2020 Quality Work Plan this is indicator # 76.<br>• For the 2021 Quality Work Plan this is indicator # 67.<br>• For the 2022 Quality Work Plan this is indicator # 62.<br>(Work Plans previously attached) |
| | | Date(s) of future action planned- Ongoing | The ongoing monitoring of CAP activities will continue as applicable. |
| | | Date(s) of follow-up action(s) taken through 6/30/22 | **Standard 104, Substandard 2: There is a provision for regular reporting to the Department of Human Services (DHS) on accurate and timely QM data. The BH MCO must submit data to DHS, as specified by DHS, that enables the measurement of the BH-MCO's** |

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|---|---|---|---|
| | | | **performance. QM program description must outline timeline for submission of QM program description, work plan, annual QM summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS.**<br><br>• Magellan includes the PEPS Reporting Timeline from the PEPS Matrix as an Appendix in the Annual Program Description.<br>• Magellan includes the due dates for the activities that fall under the responsibility of the BH-MCO from the PEPS Reporting Timeline on the PEPS Matrix into the Annual Work Plan.<br>• Magellan includes the due dates for the activities that fall under the responsibility of the BH-MCO from the PEPS Reporting Timeline on the PEPS Matrix into the Program Evaluation. (2022 Work Plan previously attached.) |
| | | Date(s) of future action planned- Ongoing | • The PEPS Reporting Timeline from the PEPS Matrix is included in the Annual Program Description ongoing.<br>• The due dates for the activities that fall under the responsibility of the BH-MCO from the PEPS Reporting Timeline are included in the Annual Work Plan ongoing.<br>• The due dates for the activities that fall under the responsibility of the BH-MCO from the PEPS Reporting Timeline are included in the Program Evaluation ongoing. |
| MBH 2022.03 | Within CMS EQR Protocol 3: Compliance with Grievance System, MBH was partially compliant with Grievance and appeal systems. | Date(s) of follow-up action taken through 6/30/22 | **Standard 68.1, Substandard 2: Training rosters and training curriculums demonstrate that Complaint staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Complaints.**<br><br>Magellan conducts a Member Complaints Training for Magellan staff annually. The Member Complaint Investigation and Decision Making Training is also conducted for Magellan staff annually.<br><br>• In 2019, the annual Member Complaints Training was held on 7/10/2019.<br>• In 2020, the Member Complaints Training was held on 7/22/2020.<br>• In 2021, the Member Complaints Training was held on 4/14/2021.<br>• In 2022, the Member Complaints Training was held on 4/13/2022. |

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| | | | • In 2019, the Member Complaint Investigation and Decision Making Training was held on 1/30/2019.<br>• In 2020, the Member Complaint Investigation and Decision Making Training was held on 2/12/2020.<br>• In 2021, the Member Complaint Investigation and Decision Making Training was held on 2/17/2021.<br>• In 2022, the Member Complaint Investigation and Decision Making Training was held on 2/16/2022. |
| | | Date(s) of follow-up action taken through 6/30/22 | **Standard 68, Substandard 4: Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).**<br><br>Effective 2/1/2021, Magellan revised the Complaint decision notice format for improved readability by eliminating investigative steps and reducing documentation citations to only those pertinent to the review in each notice. |
| | | Date(s) of follow-up action taken through 6/30/22 | **Standard 68, Substandard 9: Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review.**<br><br>Magellan includes documentation of follow-up activities by using a "Substantiated Complaint Follow Up Plan" for complaints that have substantiated issues. This is a collaborative process with the provider to develop a plan to correct the issue. The plan is reviewed to ensure the provider has a continuous quality improvement monitoring mechanism in place to ensure the correction is monitored. This documentation is included in each complaint case file. Staff are trained on this workflow in the annual Complaint Investigation and Decision Making training. In 2021, this training was held on 2/17/2021. In 2022, this training was held on 2/16/2022.<br>(Training materials previously attached.) |
| | | Date(s) of follow-up | **Standard 71, Substandard 1: Interview with Grievance** |

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|---|---|---|---|
| | | action taken through 6/30/22 | **Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: 1. Internal, 2. External, 3. Expedited, 4. Fair Hearing.**<br><br>Magellan implemented a member survey process in 2021. For the 2022 Work Plan reference #73. The survey is sent to all members (or provider, if provider initiated grievance) following their complaint or grievance unless the member is homeless or the complaint or grievance is withdrawn. (2022 Work Plan previously attached.) |
| | | Date(s) of follow-up action taken through 6/30/22 | **Standard 71.1, Substandard 2: Training rosters and training curriculums identify that Grievance staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Grievances.**<br><br>Magellan conducts a Member Grievances Training for Magellan staff annually.<br><br>• In 2019, the annual Grievances Refresher Training was held on 7/24/2019.<br>• In 2020, the annual Grievances Refresher Training was held on 8/12/2020.<br>• In 2021, the annual Grievances Refresher Training was held on 3/31/2021.<br>• In 2022, the annual Grievances Refresher Training was held on 3/30/2022. |
| | | Date(s) of follow-up action taken through 6/30/22 | **Standard 72, Substandard 1: Denial notices are issued to members according to required timeframes and use the required template language.**<br><br>For all out-of-network provider denials, Magellan utilizes Denial Letter template 2b Standard Denial Template for requests that are approved other than requested.<br>(Denial Template previously attached.) |
| MBH 2022.04 | Within CMS EQR protocol 4, Validation of Network Adequacy, MBH was partially compliant with one category. | Date(s) of follow-up action taken through 6/30/22 | **Standard 78, Substandard 1: Review of County/Corporation management minutes demonstrate actions taken. BH-MCO written notification of key staff changes received within seven days-watch for high turnover, vacant positions.** |

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| | | | Delaware County addressed open staffing positions with the hire of Janet Dreitlein, MH/IDD Administrator on 10/6/20 and Gaston Gonzalez, Chief Financial Officer on 6/13/22. |

MBH: Magellan Behavioral Health; MCO: managed care organization; RY: reporting year = measurement year; BH: behavioral health; PS&R: Program Standards and Requirements; PEPS: Program Evaluation Performance Summary; CAP: corrective action plan; QI: quality improvement; QM: quality management; CQI: continuous quality improvement; LGBTQI: lesbian, gay, transgender, queer/questioning, intersex; OMHSAS: Office of Mental Health and Substance Abuse Services; SA: substance abuse.

## Root Cause Analysis and Quality Improvement Plan

For PMs that are noted as opportunities for improvement in the EQR annual technical report, BH-MCOs are required to submit:

- a goal statement;
- root cause analysis and analysis findings;
- action plan to address findings;
- implementation dates; and
- a monitoring plan to assure action is effective and to address what will be measured and how often that measurement will occur.

Following several years of underperformance in the key quality indicator areas and coinciding with the phase-in of Value-Based Payment (VBP) at the HC BH Contractor level, OMHSAS determined in 2018 that it was necessary to change the PM remediation process so that BH-MCOs would set goals for the coming year. OMHSAS directed BH-MCOs to begin focusing their RCA and CAP work on the HEDIS FUH All Ages measure and implemented a new goal-setting logic to spur performance improvement in the measure. Based on the MY2017 performance, BH-MCOs were required to submit RCAs on the HEDIS FUH All Ages 7- and/or 30-day measure and CAPs to achieve their MY 2019 goals. HC BH Contractors that scored below the 75th NCQA Quality Compass percentile were also asked to submit RCAs and CAPs. BH-MCOs submitted their RCAs and CAPs on April 1, 2019. HC BH Contractors submitted their RCAs and CAPs by April 30, 2019. As a result of this shift to a proactive process, MY 2018 goals for FUH All Ages were never set. However, MY 2018 results were calculated in late 2019 to determine RCA and "Quality Improvement Plan" (QIP) assignments, along with goals, for MY2020, and this proactive goal-setting approach has been in place ever since.

In MY 2021, MBH scored below the 75th percentile on both the 7- and 30-day measures and, as a result, was required to complete an RCA and QIP response for both measures. **Table 6.2** and **Table 6.3** present MBH's submission of its RCA and QIP for the FUH All-Ages 7-day and 30-day measures, respectively. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 6.2: MBH RCA and QIP for the FUH 7–Day Measure (All Ages)

| MBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance | |
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| ***Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?):*** | ***Describe here your overall findings. Please explain the underperformance and any racial (White vs non-White cohorts) and/or ethnic disparities using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:*** |
| As in previous years, Magellan examined the 7-Day FUH data by first breaking it down by demographic factors to determine which factors were associated with higher or lower FUH rates. Factors examined included county, age, gender, race, and ethnicity.<br>The data in the State's Tableau database was examined via "head-to-head" comparisons between populations. Special attention was given to identifying disparities related to race, comparing FUH rates for the White subpopulation with the FUH rates for each non-White race group. Magellan examined differences in FUH rates related to ethnicity via the head-to-head comparison for the Hispanic and non-Hispanic populations.<br>Magellan also sought input on barriers to FUH by surveying outpatient providers with a survey similar to that which was administered last year to inpatient providers, in order to identify any new or worsening barriers. Provider input was also gathering from Magellan's Provider Quality Advisory Committee. This input was incorporated into the list of barriers/causal factors identified in the previous Root Cause Analysis, then adjustments were made to the list of causal factors accordingly.<br>An Ishikawa "fishbone" diagram was constructed to illustrate the causal factors identified in this current Root Cause Analysis (see document "FUH RCA Fishbone 2023"). Magellan decided to combine a few causal factors into "bundles" of causal factors, because the interventions planned would address the whole bundle and not just each single factor.<br>Each identified causal factor was discussed, and the level of actionability was determined, taking into account Magellan's previous and current interventions, as well as ideas and suggestions about newly identified or newly refined causal | Please refer to Magellan's root cause analysis, in this embedded document:<br><br>Click here for the Ishikawa fishbone diagram of the root cause analysis conclusions:<br><br>Below are several Logic Models of Change for Magellan's major interventions: |

<table>
<tr><th colspan="2">MBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance</th></tr>
<tr><td>factors. Extra attention centered on how to address identified disparities related to race and ethnicity.<br>Please see the attachment “2021 7-day FUH Root Cause Analysis” for details and results of this analysis.</td><td></td></tr>
<tr><td>List out below the factors you identified in your RCA. <u>Insert more rows as needed</u> (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).</td><td>Discuss each factor’s role in contributing to underperformance and any disparities (as defined above) in the performance indicator in question. Assess its “causal weight” as well as your MCO’s current and expected capacity to address it (“actionability”).</td></tr>
<tr><td rowspan="2">People (1)<br>Co-Occurring Disorders<br>• Substance use relapse<br>• SUD not sufficiently addressed</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):<br>This factor can independently impact FUH rates and can also interact with other factors to impact FUH rates, so the causal role is critical. The causal weight for this factor is also critical, considering the quantitative (FUH rates for people with co-occurring disorders) and qualitative findings (member and provider opinions).</td></tr>
<tr><td>Current and expected actionability: High<br>Magellan continues to see multiple opportunities to continue and enhance existing interventions targeting this factor.</td></tr>
<tr><td rowspan="2">People (2)<br>Member chooses to not pursue treatment<br>• Past negative experiences with treatment<br>• Believe they do not need treatment (at precontemplation stage)</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):<br>The causal role of this factor can interact with other factors to contribute to lower FUH rates. The causal weight is important, because if someone is not far enough along in the stages of change, or if they have minimal insight about their illness then, in their view, they do not need treatment. Also, past negative experiences with treatment, even poor customer service from providers, can cause trauma, and result in avoidance of similar situations in the future.</td></tr>
<tr><td>Current and expected actionability: Moderate<br>Magellan has already made some impact on improving the customer service of outpatient providers, by bringing the results of the Front-End Customer Service Assessment to their attention. Magellan still sees an opportunity to help providers increase skills in working with people at pre-contemplation.</td></tr>
<tr><td rowspan="2">People (3)<br>Member has trauma-Related diagnosis and/or significant history of trauma</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):<br>The causal role of this factor can interact with other factors to contribute to lower FUH rates. The causal weight is important, because experience with trauma, and re-traumatization in past episodes of BH care, they may avoid attending FUH care.</td></tr>
<tr><td>Current and expected actionability: Moderate<br>Magellan sees an opportunity to help providers improve in how they address trauma directly, and how they can enhance trauma-informed care to reduce risk of re-traumatization.</td></tr>
</table>

| MBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance | |
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| *People (4)*<br>***Member-specific demographic factors***<br>• ***Member-specific Social Determinants of Health (SDoH) factors that present barriers to FUH***<br>• ***Member-specific cultural factors that may be associated with higher or lower FUH (for example, members who are Black/ African American show lower FUH rates than members who identify as white).***<br>• ***Member speaks a language other than English*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>Factors related to a member demographics, including socioeconomic status, interact with other factors to have an unknown causal role in low follow-up rates. For example, a person's race per se may not directly affect the person's ability and willingness to attend follow-up care, but SDoH factors related to socioeconomic status, which can impact some races more than others, can result in a disparate impact on follow-up. There may also be variation in the degree that people of different sub-groups feel "welcome" in treatment, perhaps due to past experiences with discrimination or related to a need for improvement in provider cultural competency. The true causal role is unknown. There were a few reports from inpatient providers about language being a barrier, but this has not appeared in Magellan's data. However, when a person uses a language other than English, this can be a very important barrier in that one case. |
| | ***Current and expected actionability:*** Moderate, but indirect<br>While Magellan cannot directly mitigate or eliminate disparities that are related to race, ethnicity, socioeconomic status, and SDoH, Magellan can ensure that such factors are addressed in all discharge planning discussions, so that individualized planning can occur to address strengths and barriers that are affecting the individual member. In the rare cases in which a member needs follow-up care in a language other than English, this can be considered "very" actionable. |
| *People (5)*<br>***Member is not comfortable with telehealth*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>This factor is considered separate from whether a person has the technology to use telehealth. This factor can also combine with other barriers to decrease the chances of attending follow-up care. Data reveals that this factor is present in a minority of members, but when it is present, it is important. |
| | ***Current and expected actionability:*** Moderate<br>Personal discomfort with telehealth can be identified during a hospital stay, and steps can be taken to set up in-person services for follow-up care. If the reason for discomfort is lack of familiarity, perhaps this can be addressed during the person's inpatient stay. But if the discomfort is due to a more persistent factor such as paranoia, this would be much less actionable. Due to other factors like lack of provider staff availability, there may be instances in which only telehealth is available at a given time. |
| *People (6)*<br>***Member lacks support system that can help ensure attendance in FUH care*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>The causal role of this factor can interact with other factors to contribute to lower FUH rates. The causal weight is important, because behavioral health supports (like Case Managers, peer providers) or natural supports (like family or friends) can not only support the person in pursuing FUH care, but can physically make sure they get to the appointment. |

| MBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance | |
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| | ***Current and expected actionability:*** Moderate<br>Magellan can help providers assess whether these supports exist, and guide provider to refer for additional supports, but in many cases cannot have a direct impact. However, linkage with the Community Transition Coordinator team can have a more direct impact. |
| *Providers (1)*<br>***Inadequate Discharge Planning***<br>• ***Not enough member/parent input into discharge plan***<br>• ***Appointment made at a time or place member can't attend (too early, conflicts with work/school, too far away)***<br>• ***No clear plan for obtaining medications, including obtaining prior-authorization***<br>• ***SDoH barriers not identified and addressed sufficiently in discharge planning process***<br>• ***Lack of attention to barriers related to culture (race, ethnicity, language, LGBTQIA status, etc., in discharge planning process***<br>• ***Not involving the member's support system in discharge/aftercare planning*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>This factor in general, as well as the examples in the bullet points, has a significant causal role in lower FUH rates. The causal weight of this factor continues to be critical, as inadequate discharge planning, especially when discharge plans do not address all individual barriers to follow-up care, is likely to result in lower FUH rates. Any lack of involvement of the person's support system in aftercare planning can further decrease the chances of attending follow-up care. Therefore, attention to including existing collaterals, as referring to additional collaterals is essential. |
| | ***Current and expected actionability:*** High<br>Magellan views this as a critical area of continuing opportunity for action. Magellan's existing interventions focused on this factor can be further enhanced by "raising the bar" in our expectations of inpatient providers, as well as on Magellan's own care management team, to continue to incorporate (and enhance) Project Re-Engineered Discharge (RED) informed discharge planning components, to ensure full member input into discharge planning, to address or plan for all SDoH barriers that are affecting the individual, and to consider all cultural factors that might be associated with higher or lower follow-up rates. Magellan considers race, ethnicity, and language as cultural considerations, but also individual factors like religion, and LGBTQIA status. Additional expectations around including existing collaterals in discharge planning can be implemented, as well as referring to additional collateral supports. |
| *Providers (2)*<br>***The Philadelphia Factor***<br>• ***Philadelphia-based hospitals are showing lower FUH rates than non-Philadelphia located hospitals***<br>• ***Philadelphia hospital staff are unfamiliar with behavioral health resources in Magellan members' home counties***<br>• ***Philadelphia hospitals may benefit from additional guidance about best practices in discharge planning***<br>• ***When a member is homeless, Philadelphia hospitals refer them to a Philadelphia shelter (may be the only option temporarily) and a nearby behavioral health provider in Philadelphia*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>Analysis of FUH data by hospital location and discussion with Magellan's Clinical team has revealed that "the Philadelphia Factor" may have an important role in FUH rates. The actual cause is unknown, but the correlation with low FUH rates is clear. It was concluded that being discharged from a hospital in Philadelphia, as opposed to elsewhere, is an important factor associated with lower FUH rates. |
| | ***Current and expected actionability:*** Moderate<br>Magellan is working on enhancing discharge planning with all inpatient providers, including Philadelphia-based hospitals. However, there has not been sufficient buy-in from Philadelphia hospitals, largely because Magellan members only constitute a small portion of the people they see. A new approach with involving our Community Transition Coordinator team with a Phila based hospital may have a better chance of having an impact. |
| *Providers (3)*<br>***Outpatient provider availability*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** |

| MBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance | |
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| • ***Lack of psychiatrist time overall***<br>• ***Lak of provider openings within seven days***<br>• ***Compounded by recent staffing shortages related to "The Great Resignation"*** | This factor can both directly affect FUH rates, as well as indirectly affect them, by combining with other factors. The shortage of psychiatrists and psychiatrist time was previously identified as somewhat important in the previous versions of this RCA. But since the post-pandemic staffing challenges related to "the Great Resignation," provider staff availability barriers have been exacerbated. This is a critical issue affecting providers of all levels of care. |
| | ***Current and expected actionability:*** Moderate<br>During concurrent reviews, additional focus can be given to identifying an outpatient follow-up provider earlier in the hospital stay. This way, hospitals can alert Magellan when they are having difficulty finding an available follow-up provider. The staffing shortage, however, is a less actionable factor, as this is occurring not only in behavioral health, but in other industries as well, across the state and the nation. Magellan can continue to support providers in their recruitment and retention efforts. |
| *Providers (4)*<br>***Provider billing errors in claims related to visits that count as FUH visits*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>The causal role is currently unknown, but Magellan has been monitoring providers with denied claims (claims for visits that actually occurred, but for which some type of error was made in claim submission), and it was observed that many of these are claims for visits that would count in the numerator for HEDIS FUH rates. This could be pulling down FUH rates, when in fact, FUH visits may have occurred. |
| | ***Current and expected actionability:*** Moderate/unknown<br>If it is found that denied claims for FUH visits are negatively impacting FUH rates, the current process of "Claims projects" (remedial activities with providers to correct claims submissions) could have a positive impact. |
| *Policies / Procedures (1)*<br>***Open Access/Walk-In***<br>• ***Some outpatient providers will only offer open access/ walk-in***<br>• ***Walk-in may be the best option if this is member's informed choice*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>The causal role of this factor used to be more important than it is at present. Magellan has been able to work with providers to ensure that people coming out of hospitals receive an actual appointment. However, with the staffing challenges that arose in 2021, sometimes the walk-in option may be the best choice. It is important that the member be educated about what walk-in intake entails, and only use this option when the member agrees to it. |
| | ***Current and expected actionability:*** Moderate<br>In light of the current staffing challenges experienced by providers, this factor is less actionable than in the past. There are, however, opportunities to evaluate whether the walk-in option is an informed choice by the member. |
| *Policies / Procedures (2)*<br>***Outpatient Provider Responsiveness:***<br>•***Lack of timely response to calls/ referrals from inpatient providers*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>The causal role of lack of provider responsiveness is assessed to be critical. Magellan initiated a multi-year customer service assessment with the largest volume outpatient providers, and this |

| MBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance | |
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| •***Lack of timely response to calls from members*** | continues into 2023. |
| | ***Current and expected actionability:*** High<br>The actionability for addressing provider customer service and answering telephones is high. Magellan plans to continue and enhance the customer service assessment effort, with both aggregate reports, and individual provider reports. |
| *Provisions (1)*<br>***Lack of Transportation,***<br>***Lack of knowledge of transportation resources*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>Lack of transportation has been identified every year as having an important role in follow-up rates. Transportation is considered under the umbrella of Social Determinants of Health (SDoH), but it is important enough to warrant its own attention in this QIP. Providers also appear to lack knowledge about transportation resources and how to assist members in accessing these. These factors appear to have an important causal role resulting in lower follow-up rates. |
| | ***Current and expected actionability:*** Mixed<br>Ensuring that a member actually has transportation for the follow-up visit may be difficult, considering the time it might take to enroll in MATP, or limitations on scheduling with MATP providers. But the actionability of *increasing knowledge* of these resources and how to enroll continues to be highly actionable. |
| *Provisions (2)*<br>***Member lack of technology to make use of telehealth*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>Technology resources are also considered an SDoH factor that can have an important impact on attending follow-up care if the appointment is via telehealth. As mentioned above with transportation, this SDoH factor is separate and important enough to warrant separate attention in this QIP. In the post-pandemic world, telehealth has continued to be a regularly-used option for behavioral health services. Lack of technology needed to use telehealth greatly limits the options for a member. |
| | ***Current and expected actionability:*** Moderate<br>As an assessment of resources and barriers related to technology were to become a routine part of SDoH discussions during discharge planning, this factor can be highly actionable. In cases where a member does not possess the technology, an in-person appointment can be pursued if available. Providers can also be encouraged to help members apply for a subsidized smart phone, though this process can take longer than the average inpatient stay. However, in the current climate of staffing shortages, finding alternative in-person appointments may pose a difficulty. |
| *Provisions (3)*<br>***Some providers report challenges with the cost of language assistance services*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>This factor can have a very important causal role in the few cases in which English is not a member's preferred language. However, the number if these cases is quite small. All providers are expected to have or engage appropriate language assistance services. Having these services in place can have an important impact on the few cases in which it is needed. Member surveys |

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| | have revealed that when members have engaged in such services, they have considered them helpful. |
| | ***Current and expected actionability:*** Low<br>Magellan can continue to assess provider language assistance resources, and provide guidance in obtaining these. Magellan also can continue to routinely survey member experience with language assistance services. |

**Quality Improvement Plan for CY 2023**

***Rate Goal for 2023 (State the 2023 rate goal from your MY2021 FUH Goal Report here):*** **39.2% (7-Day FUH)**

*The factors above can be thought of as barriers to improvement. For each barrier identified on the previous page (except those deemed Not Very Important), indicate the actions planned and/or actions taken since December 2022 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, Who, and When of the action. To the extent possible, actions should fit into your overall logic model of change (taking into account the interaction of factors) and align with Primary Contractor QIPs. Then, indicate implementation date of the action, along with a plan for how your MCO will monitor that the action is being faithfully implemented. For factors of Unknown weight, please describe your plan to test for and monitor its importance with respect to the performance indicator.*

| ***Barrier*** | ***Action*** *Include those planned as well as already implemented.* | ***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)* | ***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.* |
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| *People (1)*<br>***Co-Occurring Disorders***<br>• ***Substance use relapse***<br>• ***SUD not sufficiently addressed*** | **Magellan's Co-Occurring Competence Efforts—Internal Training/Coaching**<br><br>**Incentivizing co-occurring competence among outpatient providers (Also a PIP intervention)** | 2/2021 and ongoing<br><br>7/2021 and ongoing quarterly | Will monitor:<br>--Frequency of trainings and mentoring sessions<br>--Co-Occurring Disorder subject matter expert attends monthly Acute Inpatient Rounds, and has weekly "office hours" mentoring with Care Managers<br><br>This effort is monitored via Magellan's Performance Improvement Project (PIP) effort and reported quarterly to OMHSAS and IPRO. |
| *People (2)*<br>***Member chooses to not pursue treatment***<br>• ***Past negative experiences with treatment***<br>• ***Believe they do not need treatment (at precontemplation stage)*** | **Front End Customer Service Assessments of Outpatient Providers**<br><br>**Training for Providers on Precontemplation** | 9/2020 and ongoing annually<br><br>4/28/2022 and ongoing now quarterly | Calls will be made Q2 and Q3 of 2023, followed by an aggregate report and individualized reports to providers, with improvement recommendations.<br>This is part of Magellan's Motivational Interviewing Training Series, mostly attended by SUD providers. Tracking how many acute inpatient providers and other mental health providers attend these sessions. Specific |

| MBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance | | | |
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| | | | session is planned for Q3 on addressing pre-contemplation about a mental health condition. |
| *People (3)*<br>***Member has trauma-Related diagnosis and/or significant history of trauma*** | **Trauma-Informed Care (TIC) Work Group**<br><br>**Treatment Record Review (TRR) audits include ensuring providers are assessing trauma**<br><br>**Educate providers about the relation between trauma and lower FUH rates** | 1/2023 and ongoing<br><br>1/1/2023 and ongoing<br><br>Q2 or Q3 2023 | Trauma Informed Work Group- Work group monitors the reinforcement of TIC principles monthly, including the application of trauma clinical practice guidelines in clinical decisions, discussions of TIC in provider profiling meetings, and analysis of data related to trauma and the relation to FUH rates.<br>Routine Treatment Record Review (TRR) audits include assessing for the presence of trauma screening. This can be monitored via the routine TRR audit process.<br>Document articles in QI newsletter about trauma and the impact on FUH, as well as resources in the Magellan website |
| *People (4)*<br>***Member-specific demographic factors***<br>• ***Member-specific Social Determinants of Health (SDoH) factors that present barriers to FUH***<br>• ***Member-specific cultural factors that may be associated with higher or lower FUH (for example, members who are Black/ African American show lower FUH rates than members who identify as white).***<br>• ***Member speaks a language other than English*** | **Include discussion of cultural factors in discharge planning**<br><br>**Include discussion of SDoH factors that can impact FUH in all discharge planning discussions**<br><br>**Ensure that when member prefers a language other than English that this is addressed in planning follow-up care** | Q2 2022<br><br>3/2021 and ongoing.<br><br>Tracking in new EHR Q2 2023 | Magellan's new clinical electronic health record is in the implementation stage, and reports are being planned to identify cases in which the member has significant SDoH barriers, a language preference other than English, other cultural barriers that can impact FUH, and then those cases can be examined to ensure that follow-up after hospitalization planning included addressing those barriers.<br>Magellan can also continue to monitor the language assistance resources and capabilities via provider surveys. |
| *People (5)*<br>***Member is not comfortable with telehealth*** | **Ensure that discussion of telehealth barriers happens in the context of SDoH discussion during discharge planning** | Q2 2023 | Magellan's new clinical electronic health record is in the implementation stage, and reports are being planned to identify cases in which the member has significant SDoH barriers (including telehealth barriers), and then those cases can be examined to ensure that follow-up after hospitalization planning included addressing those barriers. |
| *People (6)*<br>***Member lacks support system that can help ensure attendance in FUH care*** | **When member lacks supports, this an trigger referral to Community Transition Coordination (CTC) team** | Piloted in Cambria Oct 2020. Other | CTC staff will keep a tracker of all members they support, and these will also include outcomes tracking of 7-day and 30-day FUH. |

| MBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance | | | |
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| | | counties filled positions in 2022. Program fully implemented in 2023. | |
| *Providers (1)*<br>***Inadequate Discharge Planning***<br>• ***Not enough member/parent input into discharge plan***<br>• ***Appointment made at a time or place member can't attend (too early, conflicts with work/school, too far away)***<br>• ***No clear plan for obtaining medications, including obtaining prior-authorization***<br>• ***SDoH barriers not identified and addressed sufficiently in discharge planning process***<br>• ***Lack of attention to barriers related to culture (race, ethnicity, language, LGBTQIA status, etc., in discharge planning process***<br>• ***Not involving the member's support system in discharge/aftercare planning*** | **Partner with the Project RED researchers to provide education to providers, enhance use of Project-RED informed components, pilot fuller implementation of a version of RED modified for BH with select hospitals**<br><br>**Continue to require "plan to obtain meds" as part of the discharge documentation.**<br><br>**Ensure that any identified collaterals (natural or BH supports) are involved in discharge planning.**<br><br>**Ensure that any current providers are alerted when a member is hospitalized.**<br><br>**Continue to track and respond to ASC reports for "Inadequate Discharge Planning"** | Planning began 2021, implementation will be in 2023<br><br>Built in EHR (TruCare) implementing Q2 2023<br><br>Built in EHR (TruCare) implementing Q2 2023<br><br>Q1 2022<br><br>7/2020 and ongoing | Meetings with Project RED researchers are tracked Training sessions by Project RED researchers will be tracked. Provider completion of a readiness assessment is tracked. Other process measures will be determined later with the researchers.<br><br>The new EHR is in the implementation stage. Prompts have been built to ensure this covered in discharge planning discussions. Plan to build reporting capability for this as well.<br>The new EHR is in the implementation stage. Prompts have been built to ensure this covered in discharge planning discussions. Plan to build reporting capability for this as well.<br><br>Magellan System Transformation team will examine the current procedure for alerting community-based providers about inpatient admissions and determine if there are any opportunities to expand this.<br><br>Track monthly ASC data on inadequate discharge planning, and Provider intervention meetings related to discharge planning expectations. |

| MBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance | | | |
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| *Providers (2)*<br>***The Philadelphia Factor***<br>• ***Philadelphia-based hospitals are showing lower FUH rates than non-Philadelphia located hospitals***<br>• ***Philadelphia hospital staff are unfamiliar with behavioral health resources in Magellan members' home counties***<br>• ***Philadelphia hospitals may benefit from additional guidance about best practices in discharge planning***<br>• ***When a member is homeless, Philadelphia hospitals refer them to a Philadelphia shelter (may be the only option temporarily) and a nearby behavioral health provider in Philadelphia*** | **Community Transition Coordination (CTC) team**<br><br>**Continue to track and respond to ASC reports for "Inadequate Discharge Planning"** | Piloted in Cambria Oct 2020. Other counties filled positions in 2022. Program fully implemented in 2023.<br><br>Began 7/2020 and ongoing | Community Transition Team will soon be working closely with one major Philadelphia-based Acute Inpatient provider. The case tracker will be the method to monitor.<br><br>Track monthly ASC data on inadequate discharge planning, specifically for Philadelphia hospitals, and Provider intervention meetings related to discharge planning expectations. |
| *Providers (3)*<br>***Outpatient provider availability***<br>• ***Lack of psychiatrist time overall***<br>• ***Lak of provider openings within seven days***<br>• ***Compounded by recent staffing shortages related to "The Great Resignation"*** | **Continue to track instances of "Access Barriers" in ASC system**<br><br>**Rate increases to ensure competitive wages**<br><br>**Lump sum staffing recruitment and retention payments to providers** | 7/2020 and ongoing<br><br>Began 2021, continue in 2023<br><br>Initiated 2021 for 2022, continued in 2022 for 2023 | Track monthly ASC data on Access Barriers, and Provider intervention meetings related to discharge planning expectations.<br><br>Tracked by Network and System Transformation teams (amounts, dates).<br>Tracked by Network and System Transformation teams. |
| *Providers (4)*<br>***Provider billing challenges for visits that count as FUH visits*** | **Network team is promptly connecting with providers in "claims projects" to resolve denied claims issues** | Q1 2022 and continuing | On a monthly basis the Network team reviews claim denial trends for each county. Any provider identified as an outlier is engaged in a "Claims Project" to resolve. Positive outcomes of this interventions are discussed and documented in Network Strategy meetings monthly. |
| *Policies / Procedures (1)*<br>***Open Access/Walk-In***<br>• ***Some outpatient providers will only*** | **Continue to track and respond to ASC reports of walk-in only being offered to members discharging from** | 7/2020 and ongoing | Track monthly ASC data on walk-in FUH visits and related access barriers and intervention communication/meetings related to Magellan's |

| MBH RCA and QIP for the FUH 7–Day Measure (All Ages) for MY 2021 Underperformance | | | |
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| ***offer open access/ walk-in***<br>• ***Walk-in may be the best option if this is member's informed choice*** | **hospitals and other 24-hour care who did not understand and agree to walk-in** | | expectations. |
| *Policies / Procedures (2)*<br>***Outpatient Provider Responsiveness:***<br>•***Lack of timely response to calls/ referrals from inpatient providers***<br>•***Lack of timely response to calls from members*** | **Front End Customer Service Assessments of OP Providers**<br><br>**Track instances of "Access Barriers" in ASC system** | 9/2020 and ongoing<br><br>7/2020 and ongoing | Calls will be made Q2 and Q3 of 2022, followed by an aggregate report and individualized reports to providers.<br><br>Track monthly ASC data on access barriers and intervention communication/meetings related to Magellan's expectations. |
| *Provisions (1)*<br>***Lack of Transportation,***<br>***Lack of knowledge of transportation resources*** | **Handout on enrolling in MATP developed 6/2020 and also added to Magellan of PA website. State is rolling out a new online system (FindMyRide) for setting up MATP.**<br><br>**Ensure that discussion of transportation resources and barriers happens in all discharge planning.**<br><br>**Provide a remote training for inpatient providers on how to access Medical Assistance Transportation Programs.** | 6/2020, will update in 2023 with new State website info<br><br>Q2 2022<br><br>To be scheduled | Continue to remind providers of MATP resources in all discharge discussions involving members identified as having no transportation resources. This can be monitored by reviewing discharge planning notes.<br><br>This can be monitored by reviewing discharge planning notes.<br><br>Will document which providers attend. |
| *Provisions (2)*<br>***Member lack of technology to make use of telehealth*** | **Include discussion of telehealth resources and barriers in discharge planning, when FUH appointment will be via telehealth.** | Q2 2023 | Magellan's new clinical electronic health record is in the implementation stage, and reports are being planned to identify cases in which the member has significant SDoH barriers, including telehealth barriers, and then those cases can be examined to ensure that follow-up after hospitalization planning included addressing those barriers. |
| *Provisions (3)*<br>***Some providers report challenges with the cost of language assistance services*** | **Gather information from providers on their current language assistance resources and needs** | Feb 2023 | Information from multiple provider surveys on providers' use of language assistance services will be consolidated, and gaps identified. |

Table 6.3: MBH RCA and QIP for the 30-Day Measure (All Ages)

| MBH RCA and QIP for the 30-Day Measure (All Ages) for MY 2021 Underperformance | |
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| ***Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?):*** | ***Describe here your overall findings. Please explain the underperformance and any racial (White vs non-White cohorts) and/or ethnic disparities using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:*** |
| As in previous years, Magellan examined the 30-Day FUH data by first breaking it down by demographic factors to determine which factors were associated with higher or lower FUH rates. Factors examined included county, age, gender, race, and ethnicity.<br>The data in the State's Tableau database was examined via "head-to-head" comparisons between populations. Special attention was given to identifying disparities related to race, comparing FUH rates for the White subpopulation with the FUH rates for each non-White race group. Magellan examined differences in FUH rates related to ethnicity via the head-to-head comparison for the Hispanic and non-Hispanic populations.<br>Magellan also sought input on barriers to FUH by surveying outpatient providers with a survey similar to that which was administered last year to inpatient providers, in order to identify any new or worsening barriers. Provider input was also gathering from Magellan's Provider Quality Advisory Committee. This input was incorporated into the list of barriers/causal factors identified in the previous Root Cause Analysis, then adjustments were made to the list of causal factors accordingly.<br>An Ishikawa "fishbone" diagram was constructed to illustrate the causal factors identified in this current Root Cause Analysis (see document "FUH RCA Fishbone 2023"). Magellan decided to combine a few causal factors into "bundles" of causal factors, because the interventions planned would address the whole bundle and not just each single factor.<br>Each identified causal factor was discussed, and the level of actionability was determined, taking into account Magellan's previous and current interventions, as well as ideas and suggestions about newly identified or newly refined causal factors. Extra attention centered on how to address identified disparities related to race and ethnicity. | Please refer to Magellan's root cause analysis, in this embedded document:<br><br>Click here for the Ishikawa fishbone diagram of the root cause analysis conclusions:<br><br>Below are several Logic Models of Change for Magellan's major interventions: |

| MBH RCA and QIP for the 30-Day Measure (All Ages) for MY 2021 Underperformance | |
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| Please see the attachment "2021 30-day FUH Root Cause Analysis" for details and results of this analysis. | |
| ***List out below the factors you identified in your RCA. <u>Insert</u> more rows as needed (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).*** | ***Discuss each factor's role in contributing to underperformance and any disparities (as defined above) in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").*** |
| *People (1)*<br>***Co-Occurring Disorders***<br>• ***Substance use relapse***<br>• ***SUD not sufficiently addressed*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>This factor can independently impact FUH rates and can also interact with other factors to impact FUH rates, so the causal role is critical. The causal weight for this factor is also critical, considering the quantitative (FUH rates for people with co-occurring disorders) and qualitative findings (member and provider opinions). |
| | ***Current and expected actionability:*** High<br>Magellan continues to see multiple opportunities to continue and enhance existing interventions targeting this factor. |
| *People (2)*<br>***Member chooses to not pursue treatment***<br>• ***Past negative experiences with treatment***<br>• ***Believe they do not need treatment (at precontemplation stage)*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>The causal role of this factor can interact with other factors to contribute to lower FUH rates. The causal weight is important, because if someone is not far enough along in the stages of change, or if they have minimal insight about their illness then, in their view, they do not need treatment. Also, past negative experiences with treatment, even poor customer service from providers, can cause trauma, and result in avoidance of similar situations in the future. |
| | ***Current and expected actionability:*** Moderate<br>Magellan has already made some impact on improving the customer service of outpatient providers, by bringing the results of the Front-End Customer Service Assessment to their attention. Magellan still sees an opportunity to help providers increase skills in working with people at pre-contemplation. |
| *People (3)*<br>***Member has trauma-Related diagnosis and/or significant history of trauma*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>The causal role of this factor can interact with other factors to contribute to lower FUH rates. The causal weight is important, because experience with trauma, and re-traumatization in past episodes of BH care, they may avoid attending FUH care. |
| | ***Current and expected actionability:*** Moderate<br>Magellan sees an opportunity to help providers improve in how they address trauma directly, and how they can enhance trauma-informed care to reduce risk of re-traumatization. |
| *People (4)*<br>***Member-specific demographic factors*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>Factors related to a member demographics, including socioeconomic status, interact with other |

<table>
<tr><th colspan="2">MBH RCA and QIP for the 30-Day Measure (All Ages) for MY 2021 Underperformance</th></tr>
<tr><td rowspan="2"><ul><li>Member-specific Social Determinants of Health (SDoH) factors that present barriers to FUH</li><li>Member-specific cultural factors that may be associated with higher or lower FUH (for example, members who are Black/ African American show lower FUH rates than members who identify as white).</li><li>Member speaks a language other than English</li></ul></td><td>factors to have an unknown causal role in low follow-up rates. For example, a person’s race per se may not directly affect the person’s ability and willingness to attend follow-up care, but SDoH factors related to socioeconomic status, which can impact some races more than others, can result in a disparate impact on follow-up. There may also be variation in the degree that people of different sub-groups feel “welcome” in treatment, perhaps due to past experiences with discrimination or related to a need for improvement in provider cultural competency. The true causal role is unknown. There were a few reports from inpatient providers about language being a barrier, but this has not appeared in Magellan’s data. However, when a person uses a language other than English, this can be a very important barrier in that one case.</td></tr>
<tr><td>Current and expected actionability: Moderate, but indirect<br>While Magellan cannot directly mitigate or eliminate disparities that are related to race, ethnicity, socioeconomic status, and SDoH, Magellan can ensure that such factors are addressed in all discharge planning discussions, so that individualized planning can occur to address strengths and barriers that are affecting the individual member. In the rare cases in which a member needs follow-up care in a language other than English, this can be considered “very” actionable.</td></tr>
<tr><td rowspan="2">People (5)<br>Member is not comfortable with telehealth</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):<br>This factor is considered separate from whether a person has the technology to use telehealth. This factor can also combine with other barriers to decrease the chances of attending follow-up care. Data reveals that this factor is present in a minority of members, but when it is present, it is important.</td></tr>
<tr><td>Current and expected actionability: Moderate<br>Personal discomfort with telehealth can be identified during a hospital stay, and steps can be taken to set up in-person services for follow-up care. If the reason for discomfort is lack of familiarity, perhaps this can be addressed during the person’s inpatient stay. But if the discomfort is due to a more persistent factor such as paranoia, this would be much less actionable. Due to other factors like lack of provider staff availability, there may be instances in which only telehealth is available at a given time.</td></tr>
<tr><td rowspan="2">People (6)<br>Member lacks support system that can help ensure attendance in FUH care</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):<br>The causal role of this factor can interact with other factors to contribute to lower FUH rates. The causal weight is important, because behavioral health supports (like Case Managers, peer providers) or natural supports (like family or friends) can not only support the person in pursuing FUH care, but can physically make sure they get to the appointment.</td></tr>
<tr><td>Current and expected actionability: Moderate<br>Magellan can help providers assess whether these supports exist, and guide provider to refer for additional supports, but in many cases cannot have a direct impact. However, linkage with</td></tr>
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<tr><th colspan="2">MBH RCA and QIP for the 30-Day Measure (All Ages) for MY 2021 Underperformance</th></tr>
<tr><td></td><td>the Community Transition Coordinator team can have a more direct impact.</td></tr>
<tr><td rowspan="2">Providers (1)<br>Inadequate Discharge Planning<br>• Not enough member/parent input into discharge plan<br>• Appointment made at a time or place member can't attend (too early, conflicts with work/school, too far away)<br>• No clear plan for obtaining medications, including obtaining prior-authorization<br>• SDoH barriers not identified and addressed sufficiently in discharge planning process<br>• Lack of attention to barriers related to culture (race, ethnicity, language, LGBTQIA status, etc., in discharge planning process<br>• Not involving the member's support system in discharge/aftercare planning</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):<br>This factor in general, as well as the examples in the bullet points, has a significant causal role in lower FUH rates. The causal weight of this factor continues to be critical, as inadequate discharge planning, especially when discharge plans do not address all individual barriers to follow-up care, is likely to result in lower FUH rates. Any lack of involvement of the person's support system in aftercare planning can further decrease the chances of attending follow-up care. Therefore, attention to including existing collaterals, as referring to additional collaterals is essential.</td></tr>
<tr><td>Current and expected actionability: High<br>Magellan views this as a critical area of continuing opportunity for action. Magellan's existing interventions focused on this factor can be further enhanced by "raising the bar" in our expectations of inpatient providers, as well as on Magellan's own care management team, to continue to incorporate (and enhance) Project Re-Engineered Discharge (RED) informed discharge planning components, to ensure full member input into discharge planning, to address or plan for all SDoH barriers that are affecting the individual, and to consider all cultural factors that might be associated with higher or lower follow-up rates. Magellan considers race, ethnicity, and language as cultural considerations, but also individual factors like religion, and LGBTQIA status. Additional expectations around including existing collaterals in discharge planning can be implemented, as well as referring to additional collateral supports.</td></tr>
<tr><td rowspan="2">Providers (2)<br>The Philadelphia Factor<br>• Philadelphia-based hospitals are showing lower FUH rates than non-Philadelphia located hospitals<br>• Philadelphia hospital staff are unfamiliar with behavioral health resources in Magellan members' home counties<br>• Philadelphia hospitals may benefit from additional guidance about best practices in discharge planning<br>• When a member is homeless, Philadelphia hospitals refer them to a Philadelphia shelter (may be the only option temporarily) and a nearby behavioral health provider in Philadelphia</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):<br>Analysis of FUH data by hospital location and discussion with Magellan's Clinical team has revealed that "the Philadelphia Factor" may have an important role in FUH rates. The actual cause is unknown, but the correlation with low FUH rates is clear. It was concluded that being discharged from a hospital in Philadelphia, as opposed to elsewhere, is an important factor associated with lower FUH rates.</td></tr>
<tr><td>Current and expected actionability: Moderate<br>Magellan is working on enhancing discharge planning with all inpatient providers, including Philadelphia-based hospitals. However, there has not been sufficient buy-in from Philadelphia hospitals, largely because Magellan members only constitute a small portion of the people they see. A new approach with involving our Community Transition Coordinator team with a Phila based hospital may have a better chance of having an impact.</td></tr>
<tr><td>Providers (3)<br>Outpatient provider availability<br>• Lack of psychiatrist time overall</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):<br>This factor can both directly affect FUH rates, as well as indirectly affect them, by combining with other factors. The shortage of psychiatrists and psychiatrist time was previously identified</td></tr>
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<tr><th colspan="2">MBH RCA and QIP for the 30-Day Measure (All Ages) for MY 2021 Underperformance</th></tr>
<tr><td rowspan="2"><ul><li>Lak of provider openings within seven days</li><li>Compounded by recent staffing shortages related to “The Great Resignation”</li></ul></td><td>as somewhat important in the previous versions of this RCA. But since the post-pandemic staffing challenges related to “the Great Resignation,” provider staff availability barriers have been exacerbated. This is a critical issue affecting providers of all levels of care.</td></tr>
<tr><td>Current and expected actionability: Moderate<br>During concurrent reviews, additional focus can be given to identifying an outpatient follow-up provider earlier in the hospital stay. This way, hospitals can alert Magellan when they are having difficulty finding an available follow-up provider. The staffing shortage, however, is a less actionable factor, as this is occurring not only in behavioral health, but in other industries as well, across the state and the nation. Magellan can continue to support providers in their recruitment and retention efforts.</td></tr>
<tr><td rowspan="2">Providers (4)<br>Provider billing errors in claims related to visits that count as FUH visits</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):<br>The causal role is currently unknown, but Magellan has been monitoring providers with denied claims (claims for visits that actually occurred, but for which some type of error was made in claim submission), and it was observed that many of these are claims for visits that would count in the numerator for HEDIS FUH rates. This could be pulling down FUH rates, when in fact, FUH visits may have occurred.</td></tr>
<tr><td>Current and expected actionability: Moderate/unknown<br>If it is found that denied claims for FUH visits are negatively impacting FUH rates, the current process of “Claims projects” (remedial activities with providers to correct claims submissions) could have a positive impact.</td></tr>
<tr><td rowspan="2">Policies / Procedures (1)<br>Open Access/Walk-In<ul><li>Some outpatient providers will only offer open access/ walk-in</li><li>Walk-in may be the best option if this is member’s informed choice</li></ul></td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):<br>The causal role of this factor used to be more important than it is at present. Magellan has been able to work with providers to ensure that people coming out of hospitals receive an actual appointment. However, with the staffing challenges that arose in 2021, sometimes the walk-in option may be the best choice. It is important that the member be educated about what walk-in intake entails, and only use this option when the member agrees to it.</td></tr>
<tr><td>Current and expected actionability: Moderate<br>In light of the current staffing challenges experienced by providers, this factor is less actionable than in the past. There are, however, opportunities to evaluate whether the walk-in option is an informed choice by the member.</td></tr>
<tr><td rowspan="2">Policies / Procedures (2)<br>Outpatient Provider Responsiveness:<ul><li>Lack of timely response to calls/ referrals from inpatient providers</li></ul>•Lack of timely response to calls from members</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):<br>The causal role of lack of provider responsiveness is assessed to be critical. Magellan initiated a multi-year customer service assessment with the largest volume outpatient providers, and this continues into 2023.</td></tr>
<tr><td>Current and expected actionability: High</td></tr>
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| MBH RCA and QIP for the 30-Day Measure (All Ages) for MY 2021 Underperformance | |
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| | The actionability for addressing provider customer service and answering telephones is high. Magellan plans to continue and enhance the customer service assessment effort, with both aggregate reports, and individual provider reports. |
| *Provisions (1)*<br>***Lack of Transportation,***<br>***Lack of knowledge of transportation resources*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>Lack of transportation has been identified every year as having an important role in follow-up rates. Transportation is considered under the umbrella of Social Determinants of Health (SDoH), but it is important enough to warrant its own attention in this QIP. Providers also appear to lack knowledge about transportation resources and how to assist members in accessing these. These factors appear to have an important causal role resulting in lower follow-up rates. |
| | ***Current and expected actionability:*** Mixed<br>Ensuring that a member actually has transportation for the follow-up visit may be difficult, considering the time it might take to enroll in MATP, or limitations on scheduling with MATP providers. But the actionability of *increasing knowledge* of these resources and how to enroll continues to be highly actionable. |
| *Provisions (2)*<br>***Member lack of technology to make use of telehealth*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>Technology resources are also considered an SDoH factor that can have an important impact on attending follow-up care if the appointment is via telehealth. As mentioned above with transportation, this SDoH factor is separate and important enough to warrant separate attention in this QIP. In the post-pandemic world, telehealth has continued to be a regularly-used option for behavioral health services. Lack of technology needed to use telehealth greatly limits the options for a member. |
| | ***Current and expected actionability:*** Moderate<br>As an assessment of resources and barriers related to technology were to become a routine part of SDoH discussions during discharge planning, this factor can be highly actionable. In cases where a member does not possess the technology, an in-person appointment can be pursued if available. Providers can also be encouraged to help members apply for a subsidized smart phone, though this process can take longer than the average inpatient stay. However, in the current climate of staffing shortages, finding alternative in-person appointments may pose a difficulty. |
| *Provisions (3)*<br>***Some providers report challenges with the cost of language assistance services*** | ***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):***<br>This factor can have a very important causal role in the few cases in which English is not a member's preferred language. However, the number if these cases is quite small. All providers are expected to have or engage appropriate language assistance services. Having these services in place can have an important impact on the few cases in which it is needed. Member surveys have revealed that when members have engaged in such services, they have considered them |

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| | helpful. |
| | ***Current and expected actionability:*** Low<br>Magellan can continue to assess provider language assistance resources, and provide guidance in obtaining these. Magellan also can continue to routinely survey member experience with language assistance services. |

**Quality Improvement Plan for CY 2023**

***Rate Goal for 2023 (State the 2023 rate goal from your MY2021 FUH Goal Report here):*** **62.6% (30-Day FUH)**

*The factors above can be thought of as barriers to improvement. For each barrier identified on the previous page (except those deemed Not Very Important), indicate the actions planned and/or actions taken since December 2022 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, Who, and When of the action. To the extent possible, actions should fit into your overall logic model of change (taking into account the interaction of factors) and align with Primary Contractor QIPs. Then, indicate implementation date of the action, along with a plan for how your MCO will monitor that the action is being faithfully implemented. For factors of Unknown weight, please describe your plan to test for and monitor its importance with respect to the performance indicator.*

| ***Barrier*** | ***Action*** *Include those planned as well as already implemented.* | ***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)* | ***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.* |
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| *People (1)*<br>***Co-Occurring Disorders***<br>• ***Substance use relapse***<br>• ***SUD not sufficiently addressed*** | **Magellan's Co-Occurring Competence Efforts—Internal Training/Coaching**<br><br>**Incentivizing co-occurring competence among outpatient providers (Also a PIP intervention)** | 2/2021 and ongoing<br><br>7/2021 and ongoing quarterly | Will monitor:<br>--Frequency of trainings and mentoring sessions<br>--Co-Occurring Disorder subject matter expert attends monthly Acute Inpatient Rounds, and has weekly "office hours" mentoring with Care Managers<br><br>This effort is monitored via Magellan's Performance Improvement Project (PIP) effort and reported quarterly to OMHSAS and IPRO. |
| *People (2)*<br>***Member chooses to not pursue treatment***<br>• ***Past negative experiences with treatment***<br>• ***Believe they do not need treatment (at precontemplation stage)*** | **Front End Customer Service Assessments of Outpatient Providers**<br><br>**Training for Providers on Precontemplation** | 9/2020 and ongoing annually<br><br>4/28/2022 and ongoing now quarterly | Calls will be made Q2 and Q3 of 2023, followed by an aggregate report and individualized reports to providers, with improvement recommendations.<br>This is part of Magellan's Motivational Interviewing Training Series, mostly attended by SUD providers. Tracking how many acute inpatient providers and other mental health providers attend these sessions. Specific |

| MBH RCA and QIP for the 30-Day Measure (All Ages) for MY 2021 Underperformance | | | |
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| | | | session is planned for Q3 on addressing pre-contemplation about a mental health condition. |
| *People (3)*<br>***Member has trauma-Related diagnosis and/or significant history of trauma*** | **Trauma-Informed Care (TIC) Work Group**<br><br>**Treatment Record Review (TRR) audits include ensuring providers are assessing trauma**<br><br>**Educate providers about the relation between trauma and lower FUH rates** | 1/2023 and ongoing<br><br>1/1/2023 and ongoing<br><br>Q2 or Q3 2023 | Trauma Informed Work Group- Work group monitors the reinforcement of TIC principles monthly, including the application of trauma clinical practice guidelines in clinical decisions, discussions of TIC in provider profiling meetings, and analysis of data related to trauma and the relation to FUH rates.<br>Routine Treatment Record Review (TRR) audits include assessing for the presence of trauma screening. This can be monitored via the routine TRR audit process.<br>Document articles in QI newsletter about trauma and the impact on FUH, as well as resources in the Magellan website |
| *People (4)*<br>***Member-specific demographic factors***<br>• ***Member-specific Social Determinants of Health (SDoH) factors that present barriers to FUH***<br>• ***Member-specific cultural factors that may be associated with higher or lower FUH (for example, members who are Black/ African American show lower FUH rates than members who identify as white).***<br>• ***Member speaks a language other than English*** | **Include discussion of cultural factors in discharge planning**<br><br>**Include discussion of SDoH factors that can impact FUH in all discharge planning discussions**<br><br>**Ensure that when member prefers a language other than English that this is addressed in planning follow-up care** | Q2 2022<br><br>3/2021 and ongoing.<br><br>Tracking in new EHR Q2 2023 | Magellan's new clinical electronic health record is in the implementation stage, and reports are being planned to identify cases in which the member has significant SDoH barriers, a language preference other than English, other cultural barriers that can impact FUH, and then those cases can be examined to ensure that follow-up after hospitalization planning included addressing those barriers.<br>Magellan can also continue to monitor the language assistance resources and capabilities via provider surveys. |
| *People (5)*<br>***Member is not comfortable with telehealth*** | **Ensure that discussion of telehealth barriers happens in the context of SDoH discussion during discharge planning** | Q2 2023 | Magellan's new clinical electronic health record is in the implementation stage, and reports are being planned to identify cases in which the member has significant SDoH barriers (including telehealth barriers), and then those cases can be examined to ensure that follow-up after hospitalization planning included addressing those barriers. |
| *People (6)*<br>***Member lacks support system that can help ensure attendance in FUH care*** | **When member lacks supports, this an trigger referral to Community Transition Coordination (CTC) team** | Piloted in Cambria Oct 2020. Other counties | CTC staff will keep a tracker of all members they support, and these will also include outcomes tracking of 7-day and 30-day FUH. |

| MBH RCA and QIP for the 30-Day Measure (All Ages) for MY 2021 Underperformance | | | |
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| | | filled positions in 2022. Program fully implemented in 2023. | |
| *Providers (1)*<br>***Inadequate Discharge Planning***<br>• ***Not enough member/parent input into discharge plan***<br>• ***Appointment made at a time or place member can't attend (too early, conflicts with work/school, too far away)***<br>• ***No clear plan for obtaining medications, including obtaining prior-authorization***<br>• ***SDoH barriers not identified and addressed sufficiently in discharge planning process***<br>• ***Lack of attention to barriers related to culture (race, ethnicity, language, LGBTQIA status, etc., in discharge planning process***<br>• ***Not involving the member's support system in discharge/aftercare planning*** | **Partner with the Project RED researchers to provide education to providers, enhance use of Project-RED informed components, pilot fuller implementation of a version of RED modified for BH with select hospitals**<br><br>**Continue to require "plan to obtain meds" as part of the discharge documentation.**<br><br>**Ensure that any identified collaterals (natural or BH supports) are involved in discharge planning.**<br><br>**Ensure that any current providers are alerted when a member is hospitalized.**<br><br>**Continue to track and respond to ASC reports for "Inadequate Discharge Planning"** | Planning began 2021, implementation will be in 2023<br><br>Built in EHR (TruCare) implementing Q2 2023<br><br>Built in EHR (TruCare) implementing Q2 2023<br><br>Q1 2022<br><br>7/2020 and ongoing | Meetings with Project RED researchers are tracked Training sessions by Project RED researchers will be tracked. Provider completion of a readiness assessment is tracked. Other process measures will be determined later with the researchers.<br><br>The new EHR is in the implementation stage. Prompts have been built to ensure this covered in discharge planning discussions. Plan to build reporting capability for this as well.<br>The new EHR is in the implementation stage. Prompts have been built to ensure this covered in discharge planning discussions. Plan to build reporting capability for this as well.<br><br>Magellan System Transformation team will examine the current procedure for alerting community-based providers about inpatient admissions and determine if there are any opportunities to expand this.<br><br>Track monthly ASC data on inadequate discharge planning, and Provider intervention meetings related to discharge planning expectations. |
| *Providers (2)*<br>***The Philadelphia Factor***<br>• ***Philadelphia-based hospitals are showing*** | **Community Transition Coordination (CTC) team** | Piloted in Cambria Oct 2020. | Community Transition Team will soon be working closely with one major Philadelphia-based Acute Inpatient provider. The case tracker will be the method |

| MBH RCA and QIP for the 30-Day Measure (All Ages) for MY 2021 Underperformance | | | |
|---|---|---|---|
| ***lower FUH rates than non-Philadelphia located hospitals***<br>• ***Philadelphia hospital staff are unfamiliar with behavioral health resources in Magellan members' home counties***<br>• ***Philadelphia hospitals may benefit from additional guidance about best practices in discharge planning***<br>• ***When a member is homeless, Philadelphia hospitals refer them to a Philadelphia shelter (may be the only option temporarily) and a nearby behavioral health provider in Philadelphia*** | **Continue to track and respond to ASC reports for "Inadequate Discharge Planning"** | Other counties filled positions in 2022.<br>Program fully implemented in 2023.<br><br>Began 7/2020 and ongoing | to monitor.<br><br>Track monthly ASC data on inadequate discharge planning, specifically for Philadelphia hospitals, and Provider intervention meetings related to discharge planning expectations. |
| *Providers (3)*<br>***Outpatient provider availability***<br>• ***Lack of psychiatrist time overall***<br>• ***Lak of provider openings within seven days***<br>• ***Compounded by recent staffing shortages related to "The Great Resignation"*** | **Continue to track instances of "Access Barriers" in ASC system**<br><br>**Rate increases to ensure competitive wages**<br><br>**Lump sum staffing recruitment and retention payments to providers** | 7/2020 and ongoing<br><br>Began 2021, continue in 2023<br><br>Initiated 2021 for 2022, continued in 2022 for 2023 | Track monthly ASC data on Access Barriers, and Provider intervention meetings related to discharge planning expectations.<br><br>Tracked by Network and System Transformation teams (amounts, dates).<br>Tracked by Network and System Transformation teams. |
| *Providers (4)*<br>***Provider billing challenges for visits that count as FUH visits*** | **Network team is promptly connecting with providers in "claims projects" to resolve denied claims issues** | Q1 2022 and continuing | On a monthly basis the Network team reviews claim denial trends for each county. Any provider identified as an outlier is engaged in a "Claims Project" to resolve. Positive outcomes of this interventions are discussed and documented in Network Strategy meetings monthly. |
| *Policies / Procedures (1)*<br>***Open Access/Walk-In***<br>• ***Some outpatient providers will only offer open access/ walk-in***<br>• ***Walk-in may be the best option if this is member's informed choice*** | **Continue to track and respond to ASC reports of walk-in only being offered to members discharging from hospitals and other 24-hour care <u>who did not understand and agree to walk-in</u>** | 7/2020 and ongoing | Track monthly ASC data on walk-in FUH visits and related access barriers and intervention communication/meetings related to Magellan's expectations. |

| MBH RCA and QIP for the 30-Day Measure (All Ages) for MY 2021 Underperformance | | | |
|---|---|---|---|
| *Policies / Procedures (2)*<br>***Outpatient Provider Responsiveness:***<br>•***Lack of timely response to calls/ referrals from inpatient providers***<br>•***Lack of timely response to calls from members*** | **Front End Customer Service Assessments of OP Providers**<br><br>**Track instances of "Access Barriers" in ASC system** | 9/2020 and ongoing<br><br>7/2020 and ongoing | Calls will be made Q2 and Q3 of 2022, followed by an aggregate report and individualized reports to providers.<br><br>Track monthly ASC data on access barriers and intervention communication/meetings related to Magellan's expectations. |
| *Provisions (1)*<br>***Lack of Transportation,***<br>***Lack of knowledge of transportation resources*** | **Handout on enrolling in MATP developed 6/2020 and also added to Magellan of PA website. State is rolling out a new online system (FindMyRide) for setting up MATP.**<br><br>**Ensure that discussion of transportation resources and barriers happens in all discharge planning.**<br><br>**Provide a remote training for inpatient providers on how to access Medical Assistance Transportation Programs.** | 6/2020, will update in 2023 with new State website info<br><br>Q2 2022<br><br>To be scheduled | Continue to remind providers of MATP resources in all discharge discussions involving members identified as having no transportation resources. This can be monitored by reviewing discharge planning notes.<br><br>This can be monitored by reviewing discharge planning notes.<br><br>Will document which providers attend. |
| *Provisions (2)*<br>***Member lack of technology to make use of telehealth*** | **Include discussion of telehealth resources and barriers in discharge planning, when FUH appointment will be via telehealth.** | Q2 2023 | Magellan's new clinical electronic health record is in the implementation stage, and reports are being planned to identify cases in which the member has significant SDoH barriers, including telehealth barriers, and then those cases can be examined to ensure that follow-up after hospitalization planning included addressing those barriers. |
| *Provisions (3)*<br>***Some providers report challenges with the cost of language assistance services*** | **Gather information from providers on their current language assistance resources and needs** | Feb 2023 | Information from multiple provider surveys on providers' use of language assistance services will be consolidated, and gaps identified. |

MBH: Magellan Behavioral Health; RCA: root cause analysis; CAP: corrective action plan; FUH: follow-up after hospital for mental illness; LGBTQIA: lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/ally.

# VII: 2022 Strengths, Opportunities for Improvement and Recommendations

This section provides an overview of MBH's MY 2021 performance in the following areas: structure and operations standards, PIPs, and PMs, with identified strengths and opportunities for improvement. This section also provides an assessment of the strengths and weaknesses of MBH with respect to (a) quality, (b) timeliness, and (c) access to the health care services furnished by each MCO, PIHP, PAHP, or PCCM entity (as described in Title 42 CFR 438.310(c)(2)).

## Strengths

- MBH's MY 2021 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate decreased (improved) from MY 2020 to MY 2021.
- Review of compliance with MMC regulations conducted by PA in RY 2019, RY 2020, and RY 2021 found MBH to be fully compliant with standards, including Assurances of Adequate Capacity and Services, Availability of Services, Confidentiality, Coordination and Continuity of Care, Health Information Systems, Practice Guidelines, Provider Selection, Subcontractual Relationships and Delegation, and with Quality Assessment and Performance Improvement Program. This is an improvement compared to prior compliance reviews.

## Opportunities for Improvement

- Review of Compliance with Standards conducted by PA in RY 2019, RY 2020, and RY 2021 found MBH to be partially compliant with two sections associated with MMC regulations.
  - MBH was partially compliant with 1 out of 9 categories within Compliance with Standards, Including Enrollee Rights and Protections. The partially compliant category is: 1) Coverage and Authorization of services.
  - MBH was partially compliant with the single category of Grievance and Appeal Systems within Grievance System.
- MBH's MY 2021 HEDIS 7- and 30-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for ages 18–64, 6+, and 6–17 years did not achieve the goal of meeting or exceeding the HEDIS 75th percentile.
- MBH's PA-specific 7- and 30-day Follow-Up After Hospitalization for Mental Illness MY 2021 rates (QI A and QI B) for the all-ages age set were statistically significantly worse than the previous year.
- MBH's MY 2021 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 11.75%.
- Review of Compliance with Standards conducted by PA in RY 2019, RY 2020, and RY 2021 found MBH to be partially compliant with Network Adequacy.

## Assessment of Quality, Timeliness, and Access

Responsibility for **quality** of, **timeliness** of, and **access** to health care services and supports is distributed among providers, payers, and Primary Contractors. Due to the BH carve-out within PA's HC program, BH-MCOs and PH-MCOs operate under separate contracts, with BH-MCOs contracting with non-overlapping Primary Contractors, making this distribution even more complex. That said, when it comes to improving healthcare quality, timeliness, and access, the BH-MCO can focus on factors closer to its locus of control.

**Table 7.1** details the full list of recommendations that are made for the MCO for each of the applicable EQR activities. For PIPs, the recommendations are based on the review that was conducted for MY 2021. The PIP recommendations may include issues from prior years if they remain unresolved. For PMs, the strengths and opportunities noted above in this section summarize findings from the current report, while recommendations are based on issues that were not only identified as opportunities from the current report but were also identified as outstanding opportunities from last year's EQR technical report.

Table 7.1: EQR Recommendations

| EQR Task/Measure | IPRO's Recommendation | Standards |
|---|---|---|
| **Performance Improvement Projects (PIPs)** | | |
| Prevention, Early Detection, Treatment, and Recovery (PEDTAR) for Substance Use Disorders | Opportunities for improvement were limited to clarifying discussion of preliminary findings. | Quality, Timeliness, Access |
| **Performance Measures** | | |
| HEDIS Follow-Up After Hospitalization for Mental Illness rates | Although MBH's FUH rate fell slightly in MY 2021, the decrease was smaller than the Statewide drop. MBH can build on its multifaceted RCA and QIP, which include: incorporating (and enhancing) Project Re-Engineered Discharge (RED) informed discharge planning components, lump sum staffing recruitment and retention payments to providers facing staffing shortages, and building on Health Guide- Community Transition Team, a Cambria pilot, to "support clinical team with field-based activities to guide members in transitioning from higher levels of care, navigating the health care system, and achieving optimal independence and self-management." | Timeliness, Access |
| PA Follow-Up After Hospitalization for Mental Illness rates | MBH can build on its multifaceted RCA and QIP, which include: incorporating (and enhancing) Project Re-Engineered Discharge (RED) informed discharge planning components, lump sum staffing recruitment and retention payments to providers facing staffing shortages, and building on Health Guide- Community Transition Team, a Cambria pilot, to "support clinical team with field-based activities to guide members in transitioning from higher levels of care, navigating the health care system, and achieving optimal independence and self-management." | Timeliness, Access |
| Readmission Within 30 Days of Inpatient Psychiatric Discharge | MBH's REA rate improved (decreased) significantly from MY 2020 by 1.6 percentage points. For their PEDTAR PIP, MBH identified significant opportunities for improvement in several areas, starting with high rates of AMA and AWOL discharges from high levels of SUD inpatient care. The PIP interventions as a set seek to address the entire continuum of care, including prevention and early detection as well a complex chronic disease management of comorbid conditions. MBH's multifaceted approach in its PIP targeting both member engagement but also provider training and network enhancements places the MCO in a strong position to decrease readmission rates after hospitalization for mental illness for members who also have SUD. A next logical step is to conduct Difference in Difference (DiD) tests to compare rates of improvement in REA between members who carry an SUD diagnosis and those who don't to assess whether PIP interventions are being effective. Similar analysis could be conducted for members with SPMI who are participating in the ICP program (and compared to those who are not) to determine whether specific BH-PH integration interventions are also impacting REA. | Timeliness, Access |
| **Compliance with Medicaid Managed Care Regulations** | | |
| Coverage and authorization of services | MBH was partially compliant with a substandard related to the correct use of available denial letter templates and timelines. In 2021 MBH showed an improvement in use of the correct template, but OMHSAS noted an area for improvement is ensuring the effective date is correct based upon the type of request made. IPRO concurs with OMHSAS' recommendation: MBH must ensure Denial Letters are mailed to the Member at least ten (10) days prior to the effective date of the denial of authorization for continued services. | Timeliness, Access |

| EQR Task/Measure | IPRO's Recommendation | Standards |
|---|---|---|
| Grievance and appeal systems | MBH was partially compliant with Grievance and appeal systems standard due to deficiencies associated with maintaining effective oversight of the complaint process. IPRO concurs with the findings of the corrective action plan: Decision letters need to be clear and concise by including a summary of the findings from the investigation rather than explaining the entire investigation process. IPRO concurs with the following recommendations: Magellan should develop criteria to determine when an on-site provider review is warranted (e.g., health and safety concerns). It also recommended that Magellan outline criteria to determine when follow-up is needed, and Magellan should develop a process to determine member satisfaction with the Complaint outcome and document where appropriate. MBH was also partially compliant with substandards concerned with the communication of Grievance and Fair Hearing processes, procedures and Member rights. MBH should formalize a process to follow up with members to assess satisfaction with the Grievance process. In addition, MBH should identify criteria related to onsite provider reviews and follow-up actions. | Quality, Timeliness, Access |

EQR: external quality review; MCO: managed care organization; N/A: not applicable.

# VIII: Summary of Activities

## Performance Improvement Projects

- MBH successfully implemented their PEDTAR PIP for 2021.

## Performance Measures

- MBH reported all PMs and applicable quality indicators for 2021.

## Medicaid Managed Care Regulations

- MBH was partially compliant with standards, including Coverage and Authorization of Services and Grievance System. As applicable, compliance review findings from RY 2021, RY 2020, and RY 2019 were used to make the determinations.

## Network Adequacy

- Review of Compliance with Standards conducted by PA in RY 2019, RY 2020, and RY 2021 found MBH to be partially compliant with Network Adequacy.

## Quality Studies

- DHS and OMHSAS launched ICWC in 2020. For any of its members receiving ICWC services, MBH covered those services under a Prospective Payment System rate.

## 2021 Opportunities for Improvement MCO Response

- MBH provided a response to the opportunities for improvement issued in 2021.

## 2022 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for MBH in 2022 (MY 2021). The BH-MCO will be required to prepare a response in 2023 for the noted opportunities for improvement.

# References and Notes


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# Appendices

## Appendix A. Required PEPS Substandards Pertinent to BBA Regulations

Refer to **Table A.1** for required PEPS substandards pertinent to BBA Regulations. Note that, in 2019, five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific.

Table A.1: Required PEPS Substandards Pertinent to BBA Regulations

| BBA Category | PEPS Reference | PEPS Language |
|---|---|---|
| Assurances of adequate capacity and services<br><br>Title 42 CFR § 438.207 | Substandard 1.1 | • A complete listing of all contracted and credentialed providers.<br>• Maps to demonstrate 30 minutes (20 miles) urban and 60 minutes (45 miles) rural access time frames (the mileage standard is used by DOH) for each level of care.<br>• Group all providers by type of service (e.g., all outpatient providers should be listed on the same page or consecutive pages).<br>• Excel or Access database with the following information: Name of Agency (include satellite sites); Address of Agency (and satellite sites) with zip codes; Level of Care (e.g., Partial Hospitalization, D&A Outpatient, etc.); Population served (e.g., adult, child and adolescent); Priority Population; Special Population. |
| | Substandard 1.2 | 100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met. |
| | Substandard 1.4 | BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services). |
| | Substandard 1.5 | BH-MCO has notified the Department of any drop in provider network.<br>• Monitor provider turnover.<br>• Network remains open where needed. |
| | Substandard 1.6 | BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees. |
| Availability of Services<br><br>Title 42 CFR § 438.206, Title 42 CFR § 10(h) | Substandard 1.1 | • A complete listing of all contracted and credentialed providers.<br>• Maps to demonstrate 30 minutes (20 miles) urban and 60 minutes (45 miles) rural access time frames (the mileage standard is used by DOH) for each level of care.<br>• Group all providers by type of service (e.g., all outpatient providers should be listed on the same page or consecutive pages).<br>• Excel or Access database with the following information: Name of Agency (include satellite sites); Address of Agency (and satellite sites) with zip codes; Level of Care (e.g., Partial Hospitalization, D&A Outpatient, etc.); Population served (e.g., adult, child and adolescent); Priority Population; Special Population. |
| | Substandard 1.2 | 100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met. |
| | Substandard 1.3 | Provider Exception report submitted and approved when choice of two providers is not given. |
| | Substandard 1.4 | BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services). |
| | Substandard 1.5 | BH-MCO has notified the Department of any drop in provider network.<br>• Monitor provider turnover.<br>• Network remains open where needed. |
| | Substandard 1.6 | BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees. |
| | Substandard 1.7 | Confirm FQHC providers. |

| BBA Category | PEPS Reference | PEPS Language |
|---|---|---|
| | Substandard 23.1 | BH-MCO has assessed if 5% requirement is applicable. |
| | Substandard 23.2 | BH-MCO phone answering procedures provide instruction for non-English members if 5% requirement is met. |
| | Substandard 23.3 | List of oral interpreters is available for non-English speakers. |
| | Substandard 23.4 | BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.) |
| | Substandard 23.5 | BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.) |
| | Substandard 24.1 | BH-MCO provider application includes information about handicapped accessibility. |
| | Substandard 24.2 | Provider network database contains required information for ADA compliance. |
| | Substandard 24.3 | BH-MCO phone answering uses TTY or PA telecommunication relay services. |
| | Substandard 24.4 | BH-MCO is able to access interpreter services. |
| | Substandard 24.5 | BH-MCO has the ability to accommodate people who are hard of hearing. |
| | Substandard 24.6 | BH-MCO can make alternate formats available upon request. |
| | Substandard 28.1 | Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. |
| | Substandard 28.2 | The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria. |
| | Substandard 93.1 | The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates. |
| | Substandard 93.2 | The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability. |
| | Substandard 93.3 | The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned. |
| | Substandard 93.4 | The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction. |
| Confidentiality Title 42 CFR § 438.224 | Substandard 120.1 | The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data. |
| Coordination and continuity of care<br><br>Title 42 CFR § 438.208 | Substandard 28.1 | Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. |
| | Substandard 28.2 | The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria. |
| Coverage and authorization of services<br><br>Title 42 CFR Parts § | Substandard 28.1 | Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. |
| | Substandard 28.2 | The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria. |

| BBA Category | PEPS Reference | PEPS Language |
|---|---|---|
| 438.210(a–e), Title 42 CFR § 441, Subpart B, and § 438.114 | Substandard 72.1 | Denial notices are issued to members according to required timeframes and use the required template language. |
| | Substandard 72.2 | The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DHS Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect). |
| Health information systems Title 42 CFR § 438.242 | Substandard 120.1 | The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data. |
| Practice guidelines<br><br>Title 42 CFR § 438.236 | Substandard 28.1 | Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. |
| | Substandard 28.2 | The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria. |
| | Substandard 93.1 | The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates. |
| | Substandard 93.2 | The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability. |
| | Substandard 93.3 | The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned. |
| | Substandard 93.4 | The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction. |
| Provider selection<br><br>Title 42 CFR § 438.214 | Substandard 10.1 | 100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable. |
| | Substandard 10.2 | 100% of decisions made within 180 days of receipt of application. |
| | Substandard 10.3 | Recredentialing incorporates results of provider profiling. |
| Subcontractual relationships and delegation Title 42 CFR § 438.230 | Substandard 99.1 | The BH-MCO reports monitoring results for quality of individualized service plans and treatment planning. |
| | Substandard 99.2 | The BH-MCO reports monitoring results for adverse incidents. |
| | Substandard 99.3 | The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as other medical and human services programs. |
| | Substandard 99.4 | The BH-MCO reports monitoring results for administrative compliance. |
| | Substandard 99.5 | The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals. |
| | Substandard 99.6 | Provider profiles and individual monitoring results are reviewed with providers. |
| | Substandard 99.7 | Providers are evaluated based on established goals and corrective action taken as necessary. |
| | Substandard 99.8 | The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy. |
| Quality | Substandard 91.1 | The QM Program Description clearly outlines the BH-MCO QM structure. |

| BBA Category | PEPS Reference | PEPS Language |
|---|---|---|
| assessment and performance improvement program<br><br>42 CFR § 438.330 | Substandard 91.2 | The QM Program Description clearly outlines the BH-MCO QM content. |
| | Substandard 91.3 | The QM Program Description includes the following basic elements: Performance improvement projects Collection and submission of performance measurement data Mechanisms to detect underutilization and overutilization of services Emphasis on, but not limited to, high volume/high-risk services and treatment, such as Behavioral Health Rehabilitation Services Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health needs. |
| | Substandard 91.4 | The QM Work Plan includes: Objective Aspect of care/service Scope of activity Frequency Data source Sample size Responsible person Specific, measurable, attainable, realistic and timely performance goals, as applicable. |
| | Substandard 91.5 | The QM Work Plan outlines the specific activities related to coordination and interaction with other entities, including but not limited to, Physical Health MCO's (PH-MCO). |
| | Substandard 91.6 | The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted. |
| | Substandard 91.7 | The QM Work Plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members: Access to services (routine, urgent and emergent), provider network adequacy, and penetration rates Appropriateness of service authorizations and inter-rater reliability Complaint, grievance and appeal processes; denial rates; and upheld and overturned grievance rates Treatment outcomes: readmission rate, follow-up after hospitalization rates, initiation and engagement rates, and consumer satisfaction. |
| | Substandard 91.8 | The QM Work Plan includes a provider profiling process. |
| | Substandard 91.9 | The QM Work Plan includes the specific monitoring activities conducted to evaluate access and availability to services: Telephone access and responsiveness rates Overall utilization patterns and trends including BHRS and other high volume/high risk services. |
| | Substandard 91.10 | The QM Work Plan includes monitoring activities conducted to evaluate the quality and performance of the provider network: Quality of individualized service plans and treatment planning Adverse incidents Collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance. |
| | Substandard 91.11 | The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO. |
| | Substandard 91.12 | The QM Work Plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator: Mental Health; and, Substance Abuse External Quality Review: Follow-Up After Mental Health Hospitalization QM Annual Evaluation |
| | Substandard 91.13 | The identified performance improvement projects must include the following: Measurement of performance using objective quality indicators Implementation of system interventions to achieve improvement in quality Evaluation of the effectiveness of the interventions Planning and initiation of activities for increasing or sustaining improvement Timeline for reporting status and results of each project to the Department of Human Services (DHS) Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year |
| | Substandard 91.14 | The QM Work Plan outlines other performance improvement activities to be |

| BBA Category | PEPS Reference | PEPS Language |
|---|---|---|
| | | conducted based on the findings of the Annual Evaluation and any Corrective Actions required from previous reviews. |
| | Substandard 91.15 | The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's quality management program. It includes an analysis of the BH-MCO's internal QM processes and initiatives, as outlined in the program description and the work plan. |
| | Substandard 93.1 | The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates. |
| | Substandard 93.2 | The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability. |
| | Substandard 93.3 | The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned. |
| | Substandard 93.4 | The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction. |
| | Substandard 98.1 | The BH-MCO reports monitoring results for telephone access standard and responsiveness rates. Standard: Abandonment rate |
| | Substandard 98.2 | The BH-MCO reports monitoring results for overall utilization patterns and trends, including BHRS service utilization and other high volume/high risk services patterns of over- or under-utilization. BH-MCO takes action to correct utilization problems, including patterns of over- and under-utilization. |
| | Substandard 98.3 | The BH-MCO reports monitoring results for coordination with other service agencies and schools. |
| | Substandard 104.1 | The BH-MCO must measure and report its performance using standard measures required by DHS. |
| | Substandard 104.2 | The BH MCO must submit data to DHS, as specified by DHS, that enables the measurement of the BH-MCO's performance. QM program description must outline timeline for submission of QM program description, work plan, annual QM summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS. |
| | Substandard 104.3 | Performance Improvement Plans status reported within the established time frames. |
| | Substandard 104.4 | The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan Quarterly PEPS Reports |
| Grievance and appeal systems<br><br>Title 42 CFR § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424 | Substandard 68.1 | Interview with Complaint Coordinator(s) demonstrate a clear understanding of the Complaint process including how Member rights and Complaint procedures are made known to Members, BH-MCO staff and the provider network.<br>• 1st level<br>• 2nd level<br>• External<br>• Expedited<br>• Fair Hearing |
| | Substandard 68.2 | Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process. |
| | Substandard 68.3 | 100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time. |
| | Substandard 68.4 | Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s). |
| | Substandard 68.7 | Complaint case files include documentation that Member rights and the |

| BBA Category | PEPS Reference | PEPS Language |
|---|---|---|
| | | Complaint process were reviewed with the Member. |
| | Substandard 68.9 | Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review. |
| | Substandard 71.1 | Interview with Grievance Coordinator demonstrates a clear understanding of the Grievance process, including how Grievance rights and procedures are made known to Members, BH-MCO staff and the provider network:<br>• Internal<br>• External<br>• Expedited<br>• Fair Hearing |
| | Substandard 71.2 | Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process. |
| | Substandard 71.3 | 100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time. |
| | Substandard 71.4 | Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized. |
| | Substandard 71.7 | Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member. |
| | Substandard 71.9 | Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review. |
| | Substandard 72.1 | Denial notices are issued to members according to required timeframes and use the required template language. |
| | Substandard 72.2 | The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DHS Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect). |

## Appendix B. OMHSAS-Specific PEPS Substandards

Refer to **Table B.1** for OMHSAS-specific PEPS substandards. Note that, in 2019, two contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific.

Table B.1: OMHSAS-Specific PEPS Substandards

| Category | PEPS Reference | PEPS Language |
|---|---|---|
| Care Management | | |
| Care Management (CM) Staffing | Substandard 27.7 | Other: Significant onsite review findings related to Standard 27. |
| Longitudinal Care Management (and Care Management Record Review) | Substandard 28.3 | Other: Significant onsite review findings related to Standard 28. |
| Complaints and Grievances | | |
| Complaints | Substandard 68.1.1 | Where applicable there is evidence of Primary Contractor oversight and involvement in the Complaint process, including, but not limited to: the Member Handbook, Complaint decisions, written notification letters, investigations, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns. |
| | Substandard 68.1.2 | Training rosters and training curriculums demonstrate that Complaint staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Complaints. |
| | Substandard 68.5 | A verbatim transcript and/or recording of the second level Complaint review meeting is maintained to demonstrate appropriate representation, adherence to the Complaint review meeting process, familiarity with the issues being discussed and that the decision was based on input from all panel members. |
| | Substandard 68.6 | Sign-in sheets are included for each Complaint review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality requirement. |
| | Substandard 68.8 | Complaint case files include Member and provider contacts related to the Complaint case, investigation notes and evidence, Complaint review summary and identification of all review committee participants, including name, affiliation, job title and role. |
| Grievances | Substandard 71.1.1 | Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, included but not limited to the Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns. |
| | Substandard 71.1.2 | Training rosters and training curriculums identify that Grievance staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Grievances. |
| | Substandard 71.5 | A verbatim transcript and/or recording of the Grievance review meeting is maintained to demonstrate appropriate representation, adherence to the Grievance review meeting process, familiarity with the issues being discussed and that input was provided from all panel members. |
| | Substandard 71.6 | Sign-in sheets are included for each Grievance review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality |

| Category | PEPS Reference | PEPS Language |
|---|---|---|
| | | requirement. |
| | Substandard 71.8 | Grievance case files include Member and provider contacts related to the Grievance case, Grievance review summary and identification of all review committee participants, including name, affiliation, job title and role. |
| Denials | | |
| Denials | Substandard 72.3 | BH-MCO consistently reports denial data/occurrences to OMHSAS on a monthly basis according to Appendix AA requirements. |
| Executive Management | | |
| County Executive Management | Substandard 78.5 | Other: Significant onsite review findings related to Standard 78. |
| BH-MCO Executive Management | Substandard 86.3 | Other: Significant onsite review findings related to Standard 86. |
| Enrollee Satisfaction | | |
| Consumer/Family Satisfaction | Substandard 108.3 | County's/BH-MCO's role of fiduciary (if applicable) is clearly defined, and provides supportive function as defined in the C/FST Contract, as opposed to directing the program. |
| | Substandard 108.4 | The C/FST Director is responsible for: setting program direction consistent with County direction; negotiating contract; prioritizing budget expenditures; recommending survey content and priority; and directing staff to perform high quality surveys. |
| | Substandard 108.9 | Results of surveys by provider and level of care are reflected in BH-MCO provider profiling, and have resulted in provider action to address issues identified. |

# Appendix C: Program Evaluation Performance Summary: OMHSAS-Specific Substandards for MBH Counties

OMHSAS-specific substandards are not required to fulfill BBA requirements. In 2019, two contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In RY 2021, 18 OMHSAS-specific substandards were evaluated for MBH and its contractors. **Table C.1** provides a count of the OMHSAS-specific substandards applicable in 2021, along with the relevant categories.

Table C.1: Tally of OMHSAS-Specific Substandards Reviewed for MBH

| Category (PEPS Standard) | Evaluated PEPS Substandards[1] | | PEPS Substandards Under Active Review[2] | | |
|---|---|---|---|---|---|
| | Total | NR | RY 2021 | RY 2020 | RY 2019 |
| Care Management | | | | | |
| Care Management (CM) Staffing | 1 | 0 | 0 | 0 | 1 |
| Longitudinal Care Management (and Care Management Record Review) | 1 | 0 | 0 | 0 | 1 |
| Complaints and Grievances | | | | | |
| Complaints | 5 | 0 | 0 | 0 | 5 |
| Grievances | 5 | 0 | 0 | 0 | 5 |
| Denials | | | | | |
| Denials | 1 | 0 | 1 | 0 | 0 |
| Executive Management | | | | | |
| County Executive Management | 1 | 0 | 0 | 0 | 1 |
| BH-MCO Executive Management | 1 | 0 | 0 | 0 | 1 |
| Enrollee Satisfaction | | | | | |
| Consumer/Family Satisfaction | 3 | 0 | 0 | 3 | 0 |
| **Total** | **18** | **0** | **1** | **3** | **14** |

[1] The total number of OMHSAS-specific substandards required for the evaluation of Primary Contractor/BH-MCO compliance with OMHSAS standards. Any PEPS substandards not reviewed indicate substandards that were deemed not applicable to the Primary Contractor/BH-MCO.
[2] The number of OMHSAS-specific sub-standards that came under active review during the cycle specific to the review year.
OMHSAS: Office of Mental Health & Substance Abuse Services; MBH: Magellan Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: Substandards not reviewed; RY: review year.

## Format

This document groups the monitoring standards under the subject headings Care Management, Complaints and Grievances, Denials, Executive Management, and Enrollee Satisfaction. The status of each substandard is presented as it appears in the PEPS Review Application (i.e., met, partially met, not met) and/or applicable RAI tools (i.e., complete, pending) submitted by OMHSAS. This format reflects the goal of this supplemental review, which is to assess the Primary Contractor/BH-MCO's compliance with selected ongoing OMHSAS-specific monitoring standards.

## Findings

### Care Management

The OMHSAS-specific PEPS substandards relating to Care Management are MCO-specific review standards. MBH and its Primary Contractors were evaluated on two of the two applicable substandards. Of the two substandards, MBH was compliant with both substandards. The status for these substandards is presented in **Table C.2**.

Table C.2: OMHSAS-Specific Requirements Relating to Care Management

| Category | PEPS Item | RY | Status by Primary Contractor | | |
|---|---|---|---|---|---|
| | | | Met | Partially Met | Not Met |
| Care Management | | | | | |
| Care Management (CM) Staffing | Substandard 27.7 | 2019 | All MBH Primary Contractors | - | - |
| Longitudinal Care Management (and Care Management Record Review) | Substandard 28.3 | 2019 | All MBH Primary Contractors | - | - |

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; MBH: Magellan Behavioral Health.

## Complaints and Grievances

The OMHSAS-specific PEPS substandards relating to second-level complaints and grievances include MCO-specific and county-specific review standards. MBH and its Primary Contractors were evaluated on 10 of the 10 applicable substandards. Of the 10 substandards evaluated, MBH partially met 4 substandards, as indicated in **Table C.3.**

Table C.3: OMHSAS-Specific Requirements Relating to Complaints and Grievances

| Category | PEPS Item | RY | Status by Primary Contractor | | |
|---|---|---|---|---|---|
| | | | Met | Partially Met | Not Met |
| Complaints and Grievances | | | | | |
| Complaints | Substandard 68.1.1 | 2019 | Delaware, Lehigh, Montgomery, Northampton | Bucks, Cambria | - |
| | Substandard 68.1.2 | 2019 | Bucks, Cambria, Lehigh, Montgomery, Northampton | Delaware | - |
| | Substandard 68.5 | 2019 | All MBH Primary Contractors | - | - |
| | Substandard 68.6 | 2019 | All MBH Primary Contractors | - | - |
| | Substandard 68.8 | 2019 | All MBH Primary Contractors | - | - |
| Grievances | Substandard 71.1.1 | 2019 | Bucks, Delaware, Lehigh, Montgomery, Northampton | Cambria | - |
| | Substandard 71.1.2 | 2019 | Bucks, Lehigh, Montgomery, Northampton | Cambria, Delaware | - |
| | Substandard 71.5 | 2019 | All MBH Primary Contractors | - | - |
| | Substandard 71.6 | 2019 | All MBH Primary Contractors | - | - |
| | Substandard 71.8 | 2019 | All MBH Primary Contractors | - | - |

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year.

MBH was partially compliant with Substandards 1 and 2 within PEPS Standard 68.1 (RY 2019).

**Standard 68.1:** The Primary Contractor is responsible for monitoring the Complaint process for compliance with Appendix H and the Program Evaluation Performance Summary (PEPS).

**Substandard 1:** Where applicable there is evidence of Primary Contractor oversight and involvement in the Complaint process, including, but not limited to: the Member Handbook, Complaint decisions, written notification letters, investigations, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns

**Substandard 2:** Training rosters and training curriculums demonstrate that Complaint staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Complaints.

MBH was partially compliant with Substandards 1 and 2 within Standard 71.1 (RY 2019).

**Standard 71.1:** The Primary Contractor is responsible for monitoring the Grievance process for compliance with Appendix H and the Program Evaluation Performance Summary (PEPS).

**Substandard 1:** Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, included but not limited to the Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.

**Substandard 2:** Training rosters and training curriculums identify that Grievance staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Grievances.

### Denials

The OMHSAS-specific PEPS substandard relating to Denials is an MCO-specific review standard. This substandard was added to the PEPS Application during RY 2015. MBH and its Primary Contractors were evaluated for and met the criteria of this substandard. The status for this substandard is presented in **Table C.4**.

Table C.4: OMHSAS-Specific Requirements Relating to Denials

| Category | PEPS Item | RY | Status by Primary Contractor | | |
|---|---|---|---|---|---|
| | | | Met | Partially Met | Not Met |
| Denials | | | | | |
| Denials | Substandard 72.3 | 2021 | All MBH Primary Contractors | - | - |

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; MBH: Magellan Behavioral Health.

### Executive Management

There are two OMHSAS-specific PEPS substandards relating to Executive Management; the County Executive Management substandard is a county-specific review standard, and the BH-MCO Executive Management substandard is an MCO-specific review substandard. MBH and its Primary Contractors Cambria, Lehigh, and Northampton were evaluated for the County Executive Management and were found fully compliant. MBH and all its Primary Contractors were evaluated on the BH-MCO Executive Management substandard and were compliant. The status for these substandards is presented in **Table C.5**.

Table C.5: OMHSAS-Specific Requirements Relating to Executive Management

| Category | PEPS Item | RY | Status by Primary Contractor | | |
|---|---|---|---|---|---|
| | | | Met | Partially Met | Not Met |
| Executive Management | | | | | |
| County Executive Management | Substandard 78.5 | 2020 | Cambria, Lehigh, Northampton | - | - |
| BH-MCO Executive Management | Substandard 86.3 | 2020 | All MBH Primary Contractors | - | - |

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; MBH: Magellan Behavioral Health; BH-MCO: Behavioral Health Managed Care Organization.

## Enrollee Satisfaction

The OMHSAS-specific PEPS substandards relating to Enrollee Satisfaction are county-specific review standards. All three substandards crosswalked to this category were evaluated for the five MBH Primary Contractors and were compliant on all three substandards. The status by Primary Contractor for these is presented in **Table C.6**.

Table C.6: OMHSAS-Specific Requirements Relating to Enrollee Satisfaction

| Category | PEPS Item | RY | Status by Primary Contractor | | |
|---|---|---|---|---|---|
| | | | Met | Partially Met | Not Met |
| Enrollee Satisfaction | | | | | |
| Consumer/Family Satisfaction | Substandard 108.3 | 2020 | All MBH Primary Contractors | - | - |
| | Substandard 108.4 | 2020 | All MBH Primary Contractors | - | - |
| | Substandard 108.9 | 2020 | All MBH Primary Contractors | - | - |

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; MBH: Magellan Behavioral Health.